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

November 2018

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First published: **29 January 2020**

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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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 K. 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 on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services.[2] 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 serious assaults 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 This investigation is unusual in that Mr K did not commit a homicide. On 8 September 2014 Mr K seriously assaulted his neighbour by stabbing them multiple times with a knife. He was subsequently arrested for attempted murder. We would like to express our condolences to his victim. 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 K.

Mental health history

1.6 Mr K had been in various prisons since 1986 serving time for an offence of murder committed against a pregnant teenager. During his time in prison he underwent numerous assessments and participated in several treatment programmes in both open and closed prison conditions.

1.7 Mr K was subsequently released on licence and referred to the forensic service. Mr K had been in the care of Sussex Partnership NHS Foundation Trust (to be referred to as the Trust hereafter) since October 2013. Although there was some involvement in the form of providing clinical opinions by staff from the Trust prior to this date, the Trust only became responsible for Mr K's care and treatment from October 2013.

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

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

1.8 From the documents available to us we can see that Mr K was first referred to mental health services in 1984 when he was offered a rehabilitation placement to deal with his alcohol misuse. It appears that Mr K did not take up this placement because he believed he could reduce his alcohol consumption without support.

1.9 In March 2004 diagnoses were made of emotionally unstable personality disorder and significant traits of dissocial personality disorder.

1.10 In 2006 Mr K was assessed by Dr R who concluded that there was no evidence of mental illness and found that Mr K was functioning "within the normal range of intelligence". Dr R recommended that Mr K be closely monitored when released and that it would be appropriate for a forensic psychiatrist to review him. At this time Dr R diagnosed conduct disorder in childhood, dissocial personality disorder, and possible emotionally unstable personality disorder.

1.11 We have seen no evidence of further input from mental health services until 2011 when Mr K was seen by a psychiatrist, Dr H2. During this meeting the psychiatrist noted a family history of depression and suicide and that Mr K had previously been treated with multiple psychotropic drugs. Dr H2 concluded that Mr K had an anxious personality and worried about what other people thought of him.

1.12 The same year a forensic psychologist assessed Mr K. The forensic psychologist concluded that Mr K should have an assessment completed by a forensic psychiatrist to explore any continuing mental health problems and the link (if any) between those problems and his risk.

1.13 In 2012 Mr K was seen by a mental health practitioner and reported hearing god and the devil. At this time Mr K was taking mirtazapine. The following month Mr K saw the same practitioner at which time they discussed whether Mr K would meet the criteria for detention under the Mental Health Act. The conclusion was that Mr K did not appear to meet the criteria and it was noted that Dr H2 would discuss the issue with Mr K a few weeks later. The records indicate that the mental health practitioner found no evidence of thought disorder or depression at that time.

1.14 A few months later Dr H2 noted indications of thought disorder "at times" and somatic hallucinations, but found no other symptoms that would indicate a specific diagnosis. Mr K was offered antipsychotic medication but declined, he did however agree to a change in his antidepressant medication. This change in medication appeared to settle Mr K and Dr H2 noted no evidence of thought disorder when he next saw Mr K.

1.15 In early 2013 an assessment by a forensic psychologist from Mr K's 'home team', (a team from within the Trust) Dr M1, was undertaken. The view from this assessment was that admission to a medium secure psychiatric unit was not required. Dr M1's view was Mr K had an achievable pathway from prison through approved premises that a further period of detention and assessment

(in secure hospital) would not significantly contribute to Mr K's risk reduction and risk management plans.

1.16 In July 2013 Dr R was asked to provide an opinion to the parole board on the recommendations in Dr M1's report. Dr R subsequently visited Mr K and noted that there had been three failed attempts in open prison due to drug misuse and a mental health breakdown. Dr R repeated his view that Mr K was not suitable for detention under the Mental Health Act and noted diagnoses of personality disorder, clear episodes of depression and prominent anxiety symptoms. Dr R confirmed that on release, if Mr K were to be placed in Brighton, the Trust would offer an assessment by the community forensic team.

1.17 Mr K was first seen the day after his release into the community in late October 2013 when Dr R and Mr E, a psychiatric nurse, met with him at his approved premises. Mr K's medication at that time was venlafaxine[3] 75mg daily, simvastatin 40mg daily and aspirin 75mg daily. Dr R provided a comprehensive letter to Mr K's GP outlining Mr K's original offence and details of Mr K's current presentation. Mr K was keen to have support from mental health services but indicated he was wary of seeing a psychologist because he had previously had some bad experiences. Dr R indicated it was unclear what mental health support Mr K needed at that time, but it was appropriate he was in the care of the community forensic team in the first instance. Dr R advised that Mr K would initially have weekly support from Mr E and a psychiatric review every few weeks or every month. Dr R also indicated that psychology was of "paramount importance" and that he would discuss this issue with his colleagues.

1.18 Mr K was seen by Mr E on only four more occasions between November 2013 and March 2014, despite Dr R indicating that Mr K would have weekly support from Mr E.

1.19 Dr R did not see Mr K between November 2013 and March 2014 but in March 2014 Dr R was asked to review Mr K because Approved Premises staff had expressed concerns about Mr K's conversations about his sexuality and gender.

1.20 When Dr R saw Mr K in March 2014 Mr K was still living in Approved Premises and he expressed concern about the potential for him to be moved to bed and breakfast accommodation rather than supported housing. Mr K reported feeling depressed, paranoid and suicidal and admitted he was worried about sharing the information with Dr R because he was concerned that he would be recalled to prison. Mr K chose not to increase his medication at this time.

1.21 Dr R and Mr E next saw Mr K in May 2014 shortly after he had moved into his own flat. Mr K reported being heavily involved in church life and experimenting with cross-dressing. Mr K presented as "very well" and

[3] *Venlafaxine is a type of medication often used to treat depression. https://beta.nhs.uk/medicines/venlafaxine/*

relaxed, displaying a sense of humour and confidence when discussing numerous subjects. Mr K enquired whether venlafaxine could be taken on an as required basis and was advised to speak to his GP.

1.22 In early August 2014 Dr R saw Mr K again at his request. Mr K reported low mood and thinking of suicide a great deal. Mr K was experiencing a number of financial stressors having been turned down for Personal Independence Payment (PIP).[4] Dr R noted that Mr K's mood appeared settled at that time but that Mr K was "clearly vulnerable to episodes of low mood" and that the long-term risk of this was difficult to fully assess given his life history.

Relationship with the victim

1.23 Mr K knew his victim because they were neighbours and had been so for only about two weeks. Mr K told us that he was friendly towards his victim but that he did not like them.

Offence

1.24 Official reports state that Mr K had befriended his victim who was living in a flat in the same block when Mr K carried out the unprovoked attack. "They were playing computer games when he hit [them] on the back of the head, punched [them] and stabbed [them] multiple times".[5]

1.25 Mr K gave us a very different description of the sequence of events on the day of the attack in September 2014.

Sentence

1.26 Mr K was sentenced to life with a minimum of 16 years to serve in custody. In sentencing the judge said:

> "In 1986 you stabbed a teenager to death and you were convicted of manslaughter as opposed to murder because of your mental health problems. You were given a sentence of life imprisonment and you were released in October 2013 on licence. Only a year or so after your release you attempted to murder another person by subjecting them to a vicious knife attack in their own home."

Internal investigation

1.27 The internal investigation was led by a consultant clinical psychologist and comprised a further consultant clinical psychologist, consultant psychiatrist, service director and managing director.

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[4] To be eligible for Personal Independence Payment (PIP) You must be aged 16 to 64 and have a health condition or disability where you: have had difficulties with daily living or getting around (or both) for 3 months; expect these difficulties to continue for at least 9 months (unless you're terminally ill with less than 6 months to live) www gov.uk

[5] www.thelawpages.com

1.28 The investigation considered evidence from clinical records, face to face and telephone interviews from Trust staff and a member of staff from the probation service.

1.29 Three care or service delivery problems were identified:

- Formulation of risk to others, including formulation of the index offence and a dynamic formulation of the interactions between risk indicators was not fully elaborated, and potential risk to others was under-estimated.
- All reports not available on eCPA and paper notes kept separately.
- Risk assessment and Care Programme Approach documentation inconsistent and/or incomplete.

1.30 There were five recommendations:

R1 To ensure that in cases with similar levels of complexity and risk, there is a comprehensive multidisciplinary and multi-agency assessment of risk, resulting in a dynamic risk formulation that includes a formulation of the index offence and identifies the dynamic relationship between risk factors and the actions to be taken when risk indicators emerge. Risk assessments and risk management plans to be shared across all agencies, including GPs.

R2 There should be a review of how decisions made by MAPPA[6] are communicated with clinicians working with the patient (and *vice versa*) and how these inform the risk assessment and risk management plans, and how they [are] recorded in case notes.

R3 Secure & Forensic Service leadership to ensure that systems are in place for all reports and paperwork to be uploaded on eCPA.

R4 Secure & Forensic Service leadership to remind staff of the importance of completing all paperwork (especially risk assessment documentation, care plans and case notes) accurately, consistently and on time.

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[6] *MAPPA (Multi-Agency Public Protection Arrangements) – there are three levels of MAPPA management. They are mainly based upon the level of multi-agency co-operation required with higher risk cases tending to be managed at the higher levels. Offenders will be moved up and down levels as appropriate.*

Level 1 *- Ordinary agency management is for offenders who can be managed by one or two agencies (eg Police and/or Probation). It will involve sharing information about the offender with other agencies if necessary and appropriate.*

Level 2 *- Active multi-agency management is for offenders where the ongoing involvement of several agencies is needed to manage the offender. Once at level 2, there will be regular multi-agency public protection meetings about the offender.*

Level 3 *- Same arrangements as level 2 but cases qualifying for level 3 tend to be more demanding on resources and require the involvement of senior people from the agencies, who can authorise the use of extra resources. For example , surveillance on an offender or emergency accommodation.*

R5 Secure & Forensic Service to liaise with the Probation Service to ensure that there is information-sharing and joint learning about this incident.

1.31 We support the findings of the internal investigation. Attempts were made to ensure that all staff involved in the care and treatment of Mr K received structured feedback by way of a learning event and a telephone conference call. It appears that one member of staff did not dial in for the conference call and did not attend the learning event. We therefore recommend that the Trust implements a system to ensure that all staff involved in the care and treatment being reviewed receive structured feedback from investigations in the future.

Independent investigation

1.32 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 K's care and treatment and we have spoken with Mr K, and the victim.

1.33 We have provided an assessment of the internal investigation and associated action plan.

Conclusions

1.34 It is our opinion that whilst there was always a risk that Mr K would commit a further offence of a similar gravity to his original index offence, there was little that he shared with mental health staff to indicate that this was any more likely in September 2014 than when he was first released from prison in October 2013.

1.35 There appear to be different accounts given of what Dr R did or did not recommend at the Parole Board hearing in October 2013.

- The letter from the Parole Board indicates that the Board believed that Dr R was supporting Mr K's release into the community via Approved Premises.
- Dr R has told us that this was not his recommendation, he merely told the Parole Board what support would be available from the community forensic team if Mr K were released into the community.
- The MAPPA Serious Case Review report states: "It is also clear from the MAPPA records that Sussex NHS Partnership Foundation Trust was supportive of the Level 3 panel's decision not to support [Mr K's] release."

1.36 The MAPPA Serious Case Review appears to support Dr R's statement to us. It would seem unusual for Dr R to have indicated his lack of support for Mr K to be released into the community at the MAPPA meeting, only then to present a different stance to the Parole Board shortly afterwards.

1.37 It is our view that the Parole Board should be informed about this anomaly and we suggest that this is done by the Local Adult Safeguarding Board.

1.38 The Trust was aware that Mr K was mandated to attend appointments with clinical staff. Therefore the Trust should not have left him without a care coordinator/community mental health nurse during Mr E's absence from work.

1.39 Mr K's licence also required him to cooperate fully with any care or treatment recommended by a psychiatrist, psychologist or medical practitioner. It is clear that Dr R considered that psychology was of significant importance to Mr K. In addition Mr M2 recommended a psychotherapeutic approach with Mr K. Mr K did not wish to engage with this approach, despite previously indicating to Dr R that he was keen and motivated to engage with mental health services and any other assessments and treatment they would offer him.

1.40 We can see no evidence that Dr R shared this position with Mr K's probation officer. If there had been more effective communication between the probation service and the Trust, this issue may have been discussed and further consideration of the impact on Mr K's licence given.

1.41 We consider that the only action that could have been taken by the Trust that might have prevented the attack in September 2014 would have been for the Trust to have informed Mr K's probation officer that Mr K had refused to engage in psychology.

Recommendations

1.42 This independent investigation has made eight recommendations for the Trust to address in order to further improve learning from this event.

Recommendation 1

The Trust must ensure that when the terms of a client's criminal justice/probation licence to be in the community make reference to compliance with a treatment programme, clinical teams are clear about what actions could result in a breach of the terms, and how these should be reported. This will enable teams to report potential breaches appropriately.

Recommendation 2

The Trust must ensure that the operational policy for the community forensic service provides clarity about which risk assessments are required when working with a client under the 'Risk Reduction' pathway of the policy.

Recommendation 3

The Trust must ensure that when the ‘Risk Reduction’ pathway is being used to manage a client’s care and treatment, the service has a clear plan of the intended outcome of the pathway, so that the therapeutic interventions intended to reduce the client’s risks are clear and how the outcomes are measured and monitored is also clear.

Recommendation 4

The Trust must ensure that there is clarity about when clients should and should not be subject to Care Programme Approach and that individual operational policies do not contradict the Care Programme Approach policy.

Recommendation 5

The Trust must ensure that when a client is allocated to clinicians working in separate teams, a clear plan is in place to manage how communication will be managed between those clinicians and what action should be taken by whom if any issues need to be escalated.

Recommendation 6

The Trust must ensure that when a care coordinator is not at work for extended periods of time, appropriate plans are in place for the clients on his or her caseload to receive suitable support.

Recommendation 7

The Trust must ensure that the new guidance for documenting MAPPA discussions is included in the appropriate policy.

Recommendation 8

The Trust must implement a system to ensure that structured feedback is provided to all clinicians involved in the care and treatment of a client when there has been a serious incident investigation.

Recommendation 9

Commissioners must liaise with Sussex Police to agree a suitable approach for Trusts to fulfil their Duty of Candour responsibilities when there is an ongoing police investigation.

Recommendation 10

When managing the progress of action plans, Clinical Commissioning Groups must ensure that the effectiveness of new arrangements is monitored and that appropriate responses are in place to remedy non-compliance.

Suggestion for the Local Adult Safeguarding Board

1.43 We suggest that the Local Adult Safeguarding Board formally receives and considers this report in order to review any issues highlighted for non-NHS agencies. In particular the differences in views with regard to the Parole Board information, and the police role in requesting that potential witnesses are not contacted by NHS services as part of an investigation, which may interfere with their ability to carry out obligations under the NHS Duty of Candour.

2 Independent investigation

Approach to the investigation

2.1 The independent investigation follows the Department of Health guidance on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services.[7] 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 serious assaults 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 Huw Stone, Clinical Advisor and Forensic 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[8].

2.8 We wrote to Mr K at the start of the investigation, explained the purpose of the investigation and asked to meet him. He agreed to meet with us and gave his consent for us to access the records necessary to complete the investigation. A summary of our discussion with him can be found at paragraph 2.21.

2.9 We used information from:

- Sussex Partnership NHS Foundation Trust (the Trust hereafter);
- National Probation Service;
- GP records (requested by NHSE).

[7] *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*

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

2.10 As part of our investigation we interviewed:

- Forensic Consultant Psychiatrist;
- Deputy Director, Social Work;
- Consultant Clinical Psychologist;
- Serious Incident Lead Investigator;
- Trust MAPPA Level 2 meeting representative for Hastings;
- Trust MAPPA Level 2 meeting representative for Brighton.

2.11 A full list of all documents we referenced is at Appendix B.

2.12 The draft report was shared with NHS England, the Trust, the Clinical Commissioning Group, and the National Probation Service. 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

2.13 In this investigation, we were fortunate that the victim survived and was willing to talk to us. We were aware that we had to be particularly sensitive when offering the opportunity to meet with us because we did not want to re-open distressing memories for the victim.

2.14 The victim did agree to meet with us and was accompanied by a personal advisor who had been providing them with support.

2.15 The victim has provided us with a victim impact statement. We have provided a copy of this statement to the Trust, the Clinical Commissioning Group and NHS England. We did not feel it was appropriate to replicate the whole statement within this report, however we have quoted or summarised relevant passages below.

2.16 The victim has told us that they met Mr K when they moved into their accommodation. They were struggling to come to terms with a recent family bereavement and felt that their new home was the opportunity to build on their life and provide a good place for their children when they were with them.

2.17 After the attack and following release from hospital they did not feel able to return to their home and therefore a friend acted on their behalf to organise new accommodation. The new accommodation was a bedsit in a building with a large number of other bedsits. The environment was noisy and felt threatening. Their anxiety increased significantly, and they were reliant upon others for shopping, cooking and household chores. Just the sight of particular kitchen utensils became a trigger for flashbacks to the attack.

2.18 Since that time, they have started a new cycle of cognitive behavioural therapy, moved to a quieter more settled home and started psychodynamic therapy.

2.19 The victim told us:

"Don't expect people, who need support, to access support without even having said support! For example I got an invitation to CBT for anxiety about going out and had no support available to go to the appointment!"

"I felt nobody understood that ***I*** was not able to take actions, to be proactive and I needed consistency, time and patient guidance instead of being passed over to another person. I was heavily dependent on support, lost my independence but there was, apart from a few friends who organised support (which *I* couldn´t have done!), no organisation or structure there to buffer this situation and to realise that I couldn´t cope independently at this time."

2.20 We met with the victim before the report was published. We shared the findings and talked to them about why we had made the recommendations in this report. They were invited to consider whether they wanted to meet with the Trust at the formal pre-publication meeting. It was agreed that NHS England would contact them again when the meeting had been arranged.

Contact with the perpetrator's family or close friends

2.21 When we met with Mr K he said that there were no family members he wanted us to contact. However, he did ask us to make contact with his girlfriend at the time of the offence, Miss S.

2.22 Following careful discussion with relevant professionals it was agreed that it would not be appropriate to approach Miss S to invite her to talk with us. We therefore did not pursue this line of enquiry.

Contact with the perpetrator

2.23 We first met with Mr K in prison in March 2017 and then again in August 2017. We asked him his views of his care and treatment and whether there were particular issues he wanted us to review as part of our investigation.

2.24 Mr K told us that he could not remember a discussion about the need for him to see a psychologist on release from prison. He also said he was unaware that the Parole Board made the decision to release him directly from closed conditions to the community because they believe this would ensure he had access to psychological therapy that would not have been available to him in an open prison, despite the fact that this was in the letter from the Parole Board.

2.25 Mr K's expectations were that he would see a community nurse, a psychiatrist and a social worker on release to the community.

2.26 Mr K told us that although he liked his community nurse (Mr E) when he first met him and thought that the community nurse liked him, this changed when at their second meeting Mr E told Mr K that he did not need to see him again. He felt let down and then found that he didn't trust Mr E. Mr K said that he only saw Mr E when he (Mr K) was living at the Approved Premises and didn't see him at all when he moved to his flat in April 2014.

2.27 Referring to the meeting with the community forensic team psychologist, Mr K reported that he only saw him once and that he was told he didn't need to see him again. Mr K said "if I had had to see him, I would have done so….I was quite willing to go along with it". However later in the interview with us, Mr K said that he didn't like the psychologist and he felt he was okay and didn't need to see him. Mr K did not agree that he had refused to engage with the psychologist.

2.28 Mr K told us that he felt that he was urged to move onto independent accommodation despite the fact that he had some misgivings about this. He felt that he did not have the opportunity to discuss this with the mental health team as their view was "you're moving on". Mr K said that he believed he was being "set up" by the probation service because they were pushing him to move onto independent accommodation, but acknowledged that he did not say this to Dr R.

2.29 Mr K reported that Dr R was concerned about him becoming more depressed and had increased his medication. Mr K claimed that when he told Dr R about his suicidal thoughts, he said to him "I'd be surprised if you didn't have these with your condition".

2.30 Mr K stated that he felt he didn't get enough support when he was in the community. He believed that his community psychiatric nurse should have seen him more often and described him as "a lazy ***". Mr K went on to contradict himself by saying that he was happy to move on to more independent accommodation from the Approved Premises.

2.31 Mr K felt that if Mr E had seen him after he moved to his independent accommodation, it would have helped him with his worries there. Mr K believes that he should have been offered antipsychotic medication, though he accepted that he was not suffering from a psychotic illness.

2.32 Mr K told us that when he was recalled back to prison he read a report about the mental health care he had been provided within the community. He told us that the report made him feel very angry. Mr K said that he had asked Dr R "should I be in supported housing?", but Dr R had only increased his medication. However, Mr K said that he had looked forward to his interviews with Dr R, but he expected these to have been monthly. Mr K told us that he now felt that the eight interviews he had with Dr R over the 11 months he had been in the community had been sufficient.

2.33 When Mr K began using Novel Psychoactive Substances (NPS),[9] which he referred to as "legal highs" which he bought from a shop in Brighton, he said that he didn't trust Dr R enough to tell him that he had been using these.

2.34 Mr K said that he had significant problems in accessing his benefits, not receiving any PIP payments until just after he was recalled to prison in September 2014. Mr K said that this left him significantly short of money, which was particularly a problem once he moved to his independent accommodation.

2.35 Mr K also described problems with his probation officer, who he said had changed around the time that he moved to his independent accommodation. Mr K reported that the probation officer who took over behaved like a "Nazi control freak" (sic) and gave examples that included she would not let him play at open mike events and busking, in the hope of making some money to supplement the fact he didn't have any benefits. Mr K said that she also wanted to know who he saw, so for example, he could not go out to dinner with friends, without telling her, in advance, who was going to be there. Mr K said that that he told Dr R about this and he had promised that a meeting would be arranged between them all.

2.36 There were a number of statements made by Mr K that did not fit the known facts from documentation, or the accounts given in interviews with staff. For example, Mr K's claim that he had been happy to see a psychologist in the community and would have done so, had that been asked of him. We found that Mr K did not always accept responsibility for his own actions and tended to put responsibility on others.

2.37 When we asked him directly, he accepted that there were parallels between his original offence of manslaughter and the recent attempted murder. However it is our view that it is unclear what role mental health services could have had in reducing his risk in the community.

2.38 We offered the opportunity to meet with us prior to publication of the report. We met him to talk through the findings of the report, there were no further comments to add.

Structure of the report

2.39 Section 3 provides some background to Mr K's life and tracks his time from his first significant offence in 1986 to when he was released on parole in 2013.

2.40 Section 4 sets out the details of the care and treatment provided to Mr K. We have included an anonymised summary of those staff involved in Mr K's care for ease of reference for the reader at Appendix C.

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[9] *NPS are drugs which were designed to replicate the effects of illegal substances like cannabis, cocaine and ecstasy whilst remaining legal – hence their previous name 'legal highs'*

2.41 Section 5 examines the issues arising from the care and treatment provided to Mr K and includes comment and analysis.

2.42 Section 6 provides a review of the Trust's internal investigation and reports on the progress made in addressing the organisational and operational matters identified.

2.43 Section 7 provides a review of communication by the Trust with affected parties and references Duty of Candour.

2.44 Section 8 sets out our overall analysis and recommendations.

3 Background of Mr K

3.1 We have used information from clinical reports to complete this section because Mr K did not provide us with very much information about his history when we met him.

Childhood and family background

3.2 Mr K's parents separated when he was six. He and his younger sister remained with their mother who had subsequent relationships. Mr K's half sister was born from one of those relationships. It is reported that at least one of his mother's relationships involved domestic abuse witnessed by Mr K. Mr K reported to one clinician that his mother once said to him that if he stabbed one of her violent partners he would not get into trouble because he was too young at the time. In 2006 Mr K told Dr R that his mother's final relationship was with a man who had three children, and that they all moved in to live with Mr K, his mother and siblings. Mr K reported to Dr R that the man did not treat him and his siblings well and gave preferential treatment to his own children.

3.3 Mr K described his father as a heavy drinker, however as at 2012 he had had intermittent contact with Mr K during his first sentence.

3.4 Mr K's mother had a serious mental disorder involving repeated self-harm and depressive episodes. She committed suicide by jumping off Beachy Head in December 1977 when Mr K was 10 years old. Mr K reported to one clinician that a couple of days before her death, his mother spoke of suicide and asked him to "go with her".

3.5 It is suggested that in the months before her death, social services were involved with the family and there may have been periods when Mr K and his siblings were in care.

3.6 After his mother's death Mr K lived with his father until he was taken into care.

3.7 Mr K was sexually abused aged 11 years by a 16 year old female relative. Around this time Mr K began sniffing glue and quickly became addicted.

3.8 When Mr K was 14 years old, whilst in care, Mr K was sexually abused by a male social worker. This abuse involved various sexual acts and posing for paedophilic photographs, sometimes in women's clothes. It is reported that Mr K remained in contact with his abuser for a number of years into his first prison sentence, before disclosing the abuse. We understand that the police investigated the allegations but the case never went to trial.

3.9 Mr K began drinking alcohol when he was about 14 or 15 years old and rapidly became a heavy drinker, consuming wine and up to 18 cans of beer each time. His alcohol misuse led to a referral to "psychiatry" (it is not clear whether these were specialist substance misuse services or mental health services) in 1984 following which Mr K was offered a rehabilitation placement. However Mr K declined this because he thought he could cut down without help.

3.10 Mr K first took cannabis aged 14 years after he was given it by his father. Within two or three years he was regularly smoking cannabis and also taking magic mushrooms. A year later he was also taking LSD.

3.11 In 1981, at the age of 14 years, Mr K was placed in a children's home under a full care order. During his time living here he attempted to kill himself using the chain from a toilet pull.

3.12 From September 1982 to September 1983 Mr K worked at a hostel for learning disabled adults. Initially this was on a part time basis but from June 1983 he worked at the hostel full time.

3.13 In November 1983 he got a job with a construction firm. This lasted for about a year and he did not work again.

3.14 In mid-1984 Mr K had a motorcycle accident in which he sustained a head injury. Mr K told a clinician that he was in a coma for several days afterwards.

3.15 Mr K reported to a clinician that in 1985 he was drinking about 350 units of alcohol per week and heavily using cannabis.

3.16 Mr K moved schools several times and his education was further disrupted by his poor behaviour and truanting. He was expelled from at least one school.

Personal history

3.17 Mr K began cross-dressing shortly after the death of his mother. It is reported that he did various things to procure female underwear, including stealing from washing lines and housebreaking. Mr K's behaviour came to light and he was prosecuted. Mr K reported that he was ridiculed at school and by his father once the issue became public.

3.18 It is reported that Mr K had two serious relationships before 1986. The first was between January 1984 and April 1985 and from this Mr K had a son. We believe that Mr K was violent towards this girlfriend when he was drunk and she subsequently ended the relationship because of this behaviour.

3.19 The second serious relationship ended in 1986 shortly before Mr K's homicide offence. Mr K has described this relationship to a clinician as "highly sexual" and there are reports that this girlfriend left him because of his violence towards her when he was drunk.

3.20 There are references to Mr K having developed in interest in satanism and the occult prior to 1986, however Mr K has provided differing accounts to clinicians over time.

Forensic history

3.21 Mr K has a number of previous convictions:

Year	Age	Conviction
1980	12-13 years	2 counts of theft Burglary (21 offences taken into account), 21 counts of theft, and 4 counts of attempted theft
1981	13-14 years	3 counts of theft, 2 offences of handling stolen goods taken into account
1982	14-15 years	Burglary, 1 offence of theft taken into account Theft Burglary with intent with one offence of theft and one offence of handling stolen goods taken into account
1983	15-16 years	Drunk and disorderly
1984	16-17 years	Careless driving and other motoring offences (following a road traffic accident) Criminal damage (involving an axe)
1986	18-19 years	Burglary Breach of probation order Manslaughter, diminished responsibility

3.22 Mr K's homicide conviction related to an offence committed in April 1986. The victim was a 17-year-old female acquaintance of Mr K who was about five months pregnant at the time of her death. The victim was at the flat she shared with her boyfriend who was also known to Mr K. It appears that Mr K was in the flat with the victim whilst her boyfriend was out and during this time Mr K stabbed her multiple times, stamped on her face and sexually assaulted her causing notable injuries. Mr K then attempted to set fire to her body before leaving the flat.

3.23 It is noted in a report completed by a consultant forensic psychiatrist in August 2012 that some reports state that Mr K had stated that he had a sexual encounter with his victim and that he suspected she was carrying his child. Other reports make reference to Mr K having had sadistic fantasies about the victim for some time before he killed her. Different reports again refer to Mr K perceiving his victim as someone who had all the things he wanted (relationship, child, stability etc) and that he was jealous of her.

3.24 Mr K was given a life sentence in December 1986 with a minimum tariff of three years before eventually being released from prison in October 2013.

Previous period of detention

3.25 Most of this information for this section came from information provided by Dr B's report of August 2012. This was a detailed report completed by an independent consultant forensic psychiatrist at the request of HMP Shepton Mallet for the purpose of a Parole Board hearing.

3.26 Mr K was detained in a number of different prisons between 1986 and 2013 including:

- HMP Lewes;
- HMP Wakefield;
- HMP Full Sutton;
- HMP Grendon where he completed the psycho-education programme that was broadly comparable to the Core Sex Offender Treatment Programme;
- HMP Albany, where he completed behaviour modification work;
- HMP Brixton, where he completed the Extended Sex Offender Treatment Programme in 1999 at the recommendation of a psychologist the previous year;
- HMP Frankland;
- HMP Prescoed;
- HMP Usk where he completed the Better Lives Booster Sex Offender Treatment Programme;
- HMP Leyhill;
- HMP Shepton Mallet;
- HMP Bristol;
- HMP Dartmoor.

3.27 Mr K undertook the Better Lives Booster Sex Offender Treatment Programme in HMP Usk between April and June 2005. He started the course in open conditions but completed it having returned to closed conditions. It appears that Mr K was returned to closed conditions because there were suspicions that he had been using cannabis as a coping strategy. Mr K told an assessor in November 2005 that he was unhappy about being back in closed conditions but it is unclear why he felt this way. Mr K was subsequently returned to open

conditions in about August 2005 after a drug test for cannabis returned a negative result.

3.28 From about October 2005 whilst detained in an open prison, Mr K worked in a printing firm in Cardiff five days a week. He also had four periods of community leave, all of which had been for four days. The first of these periods of leave had been to a hospital in Reading and the others to a hostel in Chichester.

3.29 In July 2006 Mr K was assessed by Dr R who concluded that Mr K was "not sufficiently insightful about his risk factors". Dr R's view at that time was that in August 2005 there was no evidence of mental illness and that Mr K was functioning "within the normal range of intelligence". Dr R recommended that Mr K be closely monitored when released and that it would be appropriate for a forensic psychiatrist to review him. If Mr K were to be placed in Dr R's catchment area then he or one of his colleagues would complete this review.

3.30 A summary from a report from a psychotherapy group (that report was undated) notes that Mr K was "considered to have some remaining issues with people in authority". The original report author is noted as surmising that it was this that had "tripped him up" in open conditions. It was felt that Mr K needed to face up to the fact that some people will be frightened of him and that although he had moved on and changed, others may not have done so. It is believed that Mr K's removal from open conditions was:

- as a result of Mr K "casually and inadvertently" challenging someone's authority;
- not taking seriously the fact that a female could feel anxious in his company

3.31 A Structured Assessment of Risk and Need (SARN) for sexual offenders completed in November 2006 explored this in more detail. In July 2006 a female member of staff at the hostel where Mr K hoped to be based on his release reported "inappropriate behaviour" from Mr K. It appears that this member of staff reported that Mr K was overfamiliar and made her feel uncomfortable. It is reported that when Mr K became aware she was pregnant he became fixated on her body, in particular her stomach, and asked questions about this. Her discomfort was such that the hostel refused to offer a placement to Mr K. The SARN report author considered that the incident suggested that there had been a serious lapse in Mr K's ability to observe social boundaries and that the risk in relation to his ability to form appropriate relationships was "unmanaged". The Treatment Need Analysis revealed a high risk which was attributed to Mr K's inability to understand the gravity of his recent behaviour at that time. The report author stated that Mr K had twice breached a probation order (in 1986) and that it was noted that recent events implied that Mr K became complacent after a time in trusted positions. The conclusion of the report was that Mr K be referred to a DSPD[10]

[10] *Dangerous and Severe Personality Disorder (DSPD) units were established to provide treatment for offenders who are: More likely than not to commit an offence that might be expected to lead to serious physical or psychological harm from which the*

unit and that initial contact had been made with HMP Frankland to determine the appropriateness of a referral there.

3.32 A report from the parole board date April 2007 indicated that Mr K was at HMP Usk and that the panel did not agree to release Mr K or transfer him to open conditions at that time. This decision was based upon:

- the report referenced in paragraph 3.31 above;
- Mr K's possession of magazines depicting violence, mutilation, sexual violence and images of pregnant women and childbirth;
- Mr K's behaviour towards a member of staff at the hostel.

3.33 The panel noted that Mr K had said that he would cooperate with an assessment by the DSPD unit at HMP Frankland and that he was open to other therapeutic interventions.

3.34 Mr K moved to HMP Shepton Mallet in May 2007 where he conduct was considered to be "good". Following completion of an Enhanced Thinking Skills (ETS) programme[11] in early 2008 he was assessed by a forensic psychologist whose report recommended to the Parole Board in 2009 that Mr K move back to an open prison. An ETS post programme report noted that Mr K needed to improve his critical reasoning and that there was a risk he might overlook problems because he was too 'laid back'. Mr K had reported that he did not think he had learned anything from the course because he had done it before.

3.35 A 2008 report noted that although Mr K had previously agreed to cooperate with an assessment by the HMP Frankland DSPD unit, since returning to HMP Shepton Mallet he had refused to do so. Mr K had also indicated that he would be making a legal challenge to the recommendations of the Parole Board panel from 2007 and that he planned to do this at the following oral hearing.

3.36 An undated psychology report was prepared at the request of Mr K's solicitors in preparation for his application for parole. The psychologist was specifically instructed to address issues of risk and conducted the assessment in September 2008. The psychologist noted that at interview Mr K "did not express any attitudes or opinions that could be taken as being antisocial or pro-criminal, or supportive of sexual offending" and that there was no suggestion that Mr K was "deliberately trying to give a false impression". The psychologist also commented that life sentence prisoners were often under great pressure to tell assessors what they wanted to hear because of the

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victim would find it difficult or impossible to recover; has a severe disorder of the personality; and a link can be demonstrated between the disorder and the risk of reoffending.

[11] *Enhanced Thinking Skills (ETS) programme aims to identify and alter the elements of thinking associated with criminal behaviour. Points such as flexible thinking, impulse control, social perspective, values and moral reasoning and solving inter-personal problems are all covered. This is the Prison Service's most widely used programme as it is quite general and applicable to a large proportion of offenders.*

threat that they will never be released unless they “address their offending behaviour”. Some of the report conclusions include:

- “The index offence is most likely to have resulted from an outburst of anger, possibly as a result of Mr K’s sexual advances being refused. It is very likely that the disinhibiting effects of alcohol raised the risk markedly at the time. There seems to be no clear evidence as to whether or not Mr K was under the influence of hallucinogenic drugs at the time but the effects of a large amount of alcohol alone would be enough to raise the risk; if drugs had been taking [sic] this would probably make things worse. Both would seriously interfere with Mr K’s memory for the event.”

- “Given Mr K’s age, lack of any other sexual offences, good behaviour, and abstinence from substances in recent years, his risk of serious offending now would appear to be low.”

- “There is every indication that Mr K shows appropriate remorse for his index offence.”

- “The precise events surrounding Mr K’s encounter with the pregnant hostel worker are difficult to determine but the evidence seen by [the psychologist] does not suggest that Mr K has a sinister interest in pregnant women.”

- “Mr K’s return to closed conditions was an overreaction caused by concentrating too much on one aspect of the index offence and over-interpreting other things as being related to it.”

3.37 The psychologist’s report states that there would be concerns if Mr K were found to be drinking heavily or using drugs and that the view about inappropriateness of Mr K’s return to closed conditions would only be changed if new evidence were presented suggesting Mr K had been actively preparing to offend against women. The psychologist was of the opinion that Mr K’s level of risk was sufficiently low to be managed in open conditions.

3.38 An Offender Management System (OASys) assessment in October 2008 found that there was a 44% likelihood of Mr K committing a “further general offence” within 12 months and a 62% likelihood of Mr K committing a “further general offence” within 24 months.

3.39 In October 2009 there was an oral hearing of the Parole Board following which the panel recommended transfer to open conditions. The panel considered the undated psychology report referred to in paragraphs 3.36 and 3.37 above and heard evidence from Mr K’s Offender Supervisor who reported that Mr K’s interactions with female staff had been appropriate and that no members of staff had expressed concerns. Mr K had told the panel “he had gone to HMP Grendon hating himself and believing he was the most evil person in the world. He emerged from there liking himself and determined to change his life around”.

3.40 Mr K was subsequently moved to HMP Leyhill in April 2010. HMP Leyhill is an open prison that offered a range of work and training opportunities in the community. Mr K appeared to be doing well but in September 2010 he absconded from a supervised independent living skills programme in Bristol. Mr K was absent for a number of hours before he gave himself up in Bath in the late evening. Two days after this, he was returned to HMP Shepton Mallet, a closed prison.

3.41 A psychology report was completed in August 2011 at the request of the Offender Management Unit at HMP Shepton Mallet. The purpose of the report was to identify whether Mr K was suitable for a progressive move or whether he needed further specific interventions to reduce his risk. The psychologist described that Mr K had made significant progress during his sentence in terms of addressing his risk. The circumstances leading to Mr K's absconding from HMP Leyhill were explored and Mr K reported that he had repeatedly told people about this fear of recall to closed conditions but that nobody recognised how intense his thoughts were. On the day be absconded Mr K reported that he woke up and thought he wanted to die because he couldn't take it anymore. He had put on two sets of clothes and had taken a number of items with him. He intended to go to Beachy Head to kill himself as his mother had done and had walked all day but had only got as far as Bath. He lost his diary, got soaking wet, developed blisters and ended up handing himself in. The view of the psychologist was that it is likely that the absconding was triggered by deteriorating mental health because Mr K had described repetitive intrusive negative thoughts alongside depressive and anxious emotions.

3.42 The psychologist considered that Mr K did not need any further intervention to address his risk of reoffending. However they did consider that Mr K should have an assessment by a forensic psychiatrist to explore any continuing mental health problems and the link (if any) between those problems and risk.

3.43 In October 2010 Mr K moved to HMP Dartmoor and was seen for a mental health assessment within two weeks of arriving. Mr K had reported low moods for many years and that he had recently started on citalopram.[12] The following month Mr K's antidepressant medication was changed from citalopram to venlafaxine. Shortly afterwards Mr K was seen by a psychiatrist who thought that Mr K was "overly focussed on past issues, ruminating about release and had some paranoid ideation but no frank delusions". At that time Mr K wanted to avoid medication and was interested in guided self-help. A decision was therefore made to reduce the venlafaxine with a plan that it would stop two weeks later.

3.44 It seems that Mr K moved back to HMP Shepton Mallet at the end of November 2010 where it was thought that he had stopped the venlafaxine too

[12] *Citalopram is an antidepressant belonging to a group of drugs called selective serotonin reuptake inhibitors (SSRIs). Citalopram is used to treat depression. www.drugs.com*

quickly. He was given three nights' worth of zopiclone[13] 7.5mg and on review said he was keen to try mirtazapine,[14] he was therefore prescribed mirtazapine 15mg daily. In January 2011 the mirtazapine was increased to 30mg daily.

3.45 Mr K was released on licence in October 2013. There were 10 conditions to his licence that included:

- "He must comply with any requirements specified by his supervising officer for the purpose of ensuring that he addresses his alcohol and substance misuse problems."
- "He must comply with any requirement specified by his supervising officer for the purpose of ensuring that he addresses his sexual offending behaviour problems, for example by undertaking a Sex Offender Treatment Programme."
- "He must attend all appointments arranged for him with a psychiatrist/psychologist and/or medical practitioner and cooperate fully with any care or treatment that they recommend."
- "He must notify his supervising officer promptly of any developing friendships or intimate relationships with women and also the breakdown thereof."

Diagnostic history

3.46 In March 2004 a consultant psychiatrist diagnosed emotionally unstable personality disorder, borderline type as being the predominant disorder experienced by Mr K at the time of the offence in 1986. The same consultant also diagnosed significant traits of dissocial personality disorder.

3.47 In July 2006 Dr R made diagnoses of:

- Conduct disorder in childhood;
- Dissocial personality disorder;
- Possible emotionally unstable personality disorder.

3.48 At this time Dr R disagreed with the previous diagnosis of emotionally unstable personality disorder being the predominant diagnosis at the time of the offence in 1986. Dr R clarified this view by noting that it was unusual for someone with this disorder to be violent to others and that in his opinion "few, if any, psychiatrists would entertain the idea that the index offence was consistent with the behavioural outbursts seen in borderline personality

[13] Zopiclone is a type of sleeping tablet used in the treatment of insomnia. The medication helps by reducing the amount of time it takes to fall asleep and increases the amount of time spent sleeping. www.ukmeds.co.uk

[14] Mirtazapine is an antidepressant. It is thought to positively affect communication between nerve cells in the central nervous systems and/or restore chemical balance in the brain. Mirtazapine is used to treat major depressive disorder. www.drugs.com

disorder". Dr B reported Dr R's view in her report dated August 2012 and noted that she disagreed with Dr R's generalisations about violence in borderline personality disorder, noting that "this is a disorder that in my experience can be associated with significant violence to others". Dr B reported that Dr R's report stated that despite all the work Mr K had done he remained of the view that Mr K represented a risk of violence to others. It appears this view was based on the nature and circumstances of the offence in 1986 and that the factors that contributed to the risk were:

- Personality disorder;
- Alcohol;
- Drugs;
- Relationship problems.

3.49 Dr R was concerned that Mr K was not sufficiently insightful about these factors and considered this to be a notable risk.

4 Care and treatment of Mr K

2006

4.1 In July 2006 Dr R wrote to Ms N2, a probation officer to provide details of an interview that he had conducted with Mr K at Ms N2's request. At that time Mr K advised that he had moved to a Category D[15] prison in 2004 and that he had been working for a printing firm five days a week. Dr R advised that he did not think Mr K had a mental illness "within the meaning of Mental Health Act". Dr R reported that Mr K had experienced a number of behavioural problems at home and at school from where he was expelled, and Dr R's conclusion that that Mr K suffered from "conduct disorder in childhood as according to ICD10"[16]. Dr R's view was that Mr K's sexual preferences were "unclear and disturbed" and he noted that Mr K had admitted to harbouring sadomasochistic sexual fantasies. Dr R's opinion was that Mr K suffered from a severe personality disorder, with the predominant features of dissocial personality disorder and possible emotionally unstable personality disorder.

4.2 Dr R was clear that it was the responsibility of the Parole Board to make the decision about if and when it was appropriate for Mr K to be released into the community. Dr R's advice was that if Mr K were to be released he should be closely monitored and that a forensic psychiatrist should be asked to review Mr K once he was in the community.

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[15] A Category D prison is an "open" prison, where inmates are permitted to leave the prison at certain times for example to work in the local community.

[16] ICD 10: International Classification of Mental and Behavioural Disorders, World Health Organisation 1992

2011

4.3 Mr K was seen on 23 February by a psychiatrist Dr H2. It appears that Mr K was at HMP Shepton Mallet at this point. A family history of depression and suicide was noted, along with the fact that Mr K had previously been treated with multiple psychotropic drugs. Mr K reported that when he feels low he had a poor appetite and sometimes stops eating, but continues to drink fluids, his sleep becomes poor and he can have thoughts of hopelessness and helplessness. Dr H2 noted that Mr K appeared to be stable on his medication at that time and that apart from depression, Mr K "has an anxious personality and he worries about what others think of him". Dr H2 also noted that Mr K had a tendency to over-analyse things and that this could make him more anxious. Dr H2's recommendation was that Mr K would benefit from CBT or anxiety management and that Mr K should remain on his medication for at least six months. Dr H2 suggested that Mr K continued to take 30mg mirtazapine until the end of July and that if he wanted to stop taking medication in August that could be explored then, however it would be appropriate to continue taking it for a year before further review.

2012

4.4 On 30 August, it appears whilst still at HMP Shepton Mallet, Mr K was seen by a practitioner ED (we have been unable to establish the name or role of this practitioner). Mr K wanted to discuss the contents and recommendations of a recent report. ED had not seen the report at that time and was therefore unable to provide comment. Mr K spent some time talking about his thoughts and questioning whether they were psychotic. Mr K described hearing god, but was unclear whether this was god or a conversation he could imagine having with god. Mr K said that he did hear the devil on occasions but reported no visual hallucinations. Mr K was continuing to take mirtazapine at this time and provided a copy of the report for ED to read.

4.5 ED next saw Mr K on 13 September when Mr K reported some confusion about some of the report content. He was able to identify what was upsetting him and spoke about this. ED discussed whether Mr K would meet the criteria for detention under the Mental Health Act and subsequent transfer to a medium secure hospital. The conclusion was that Mr K did not appear to meet the criteria and it was noted that Dr H2 would discuss it with Mr K in a few weeks. ED noted no evidence of thought disorder or depression.

4.6 On 3 October Dr H2 saw Mr K, it appears as a follow up to the detailed report to the Parole Board by Dr B that suggested possible mental illness that included psychotic features and low mood. Dr H2 noted that there were indications of thought disorder "at times" and somatic hallucinations but there were no other features that would support a specific diagnosis. Dr H2 considered that Mr K was not at acute risk at that time and suggested a trial of antipsychotic medication, however Mr K declined. Mr K did agree for his antidepressant medication to be changed to venlafaxine 75mg.

4.7 On 17 October a letter was sent from HMP Cornhill to Mr K's solicitor including copies of reports following Dr B's psychiatric assessment. The letter

highlighted the fact that Dr B recommended the prison service should seek to consider transferring Mr K to a medium secure psychiatric unit. Also referenced was a report dated 23 December 2010 by a probation officer, confirming that Mr K had been assessed by Dr B and that although a hostel placement was available in Brighton, it would not meet Mr K's complex needs. It was noted that a completed assessment by the Hellingly medium secure unit[17] or a report commissioned by Mr K's legal team would be required to progress discussions about a transfer.

4.8 On 24 October Dr H2 saw Mr K again and noted that he appeared more settled with no evidence of thought disorder. Mr K indicated no plans to kill himself but said that he thought about it when he was alone due to being unhappy in prison. Mr K described a voice that would enter his head saying "do it". Dr H2 noted that the plan was to continue with venlafaxine 75mg, reduce mirtazapine to 15 mg, and review in December to cease mirtazapine and consider whether the venlafaxine should be increased.

2013

4.9 On 10 January an assessment was commenced. The assessment took place at HMP Shepton Mallet and was completed by Dr M1, a consultant clinical psychologist from the Trust. Mr K was not sure whether the mental health pathway was required but was concerned it would prolong the period of his detention. Diagnoses given by Dr B were noted as:

- possible mood/depressive/ psychotic disorder;
- possible brain injury;
- substance misuse (drugs and alcohol);
- mixed personality disorder (dependent, anxious/avoidant, borderline and dissocial traits).

4.10 Dr M1's view was that admission to a medium secure psychiatric unit was not required. Dr M1 noted that Mr K had an achievable pathway from prison through approved premises and indicated that he did not believe that a further period of detainment and assessment would significantly contribute to previous risk reduction and risk management plans. Dr M1 stated it was his opinion that it would be in Mr K's interests to be supported by a community mental health team during his resettlement into approved premises and that he understood Dr R was supportive of this. Dr M1 noted that Mr K had a "complex and somewhat fragile presentation" and would benefit from additional support from mental health services during a period of transition, and "possibly ongoing monitoring". Mr M1 advised that a forensic community mental health team could support residential staff in approved premises, provider and monitor psychiatric treatment, support Mr K to develop relapse

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[17]Hellingly Centre is a medium secure unit for people aged over 18 who have mental health problems and who have become involved with the criminal justice system, provided by Sussex Partnership NHS Foundation Trust. *https://www.sussexpartnership.nhs.uk/service-hellingly-centre*

indicators, and signpost community resources to help Mr K develop recovery supporting activities and relationships. Mr M1 stated that "pending MAPPA classification" there was also a possibility of specialist psychological support from the Trust's forensic psychology service. Mr M1 concluded that a well-supported and closely monitored placement in approved premises had the potential to contribute significantly to the understanding of Mr K's risks and needs.

4.11 Mr M1's assessment was sent to the offender management unit at HMP Shepton Mallet on 25 January. The Trust subsequently closed the referral on 29 January, for hospital transfer but noted that Mr K would need community services on release from prison.

4.12 On 26 April Mr K and relevant professionals were notified of Mr K's parole board hearing that was scheduled to take place on 24 June.

4.13 Following the hearing the Trust received a letter on 2 July advising that the hearing had been adjourned in order that Mr K could be properly assessed by a forensic psychiatrist from "local forensic services who should identify appropriate treatment and disposal". It was noted that the adjourned hearing would take place on 2 October.

4.14 Dr M1 emailed the Trust clinical director and Dr R to highlight the fact that the approved premises being considered by the parole board were in Guildford and therefore the assessing psychiatrist would need to be aware of community services in that area.

4.15 On 10 July a referral was "opened" that indicated that Dr R was asked to provide an opinion to the parole board on the recommendations in Dr M1's report. It was noted that Dr R would arrange to see Mr K who was at HMP Maidstone by that time.

4.16 Dr R saw Mr K on 12 July and provided a report to the parole board on 22 July. Dr R noted that Mr K had three failed attempts in an open prison due to drug misuse and a mental health breakdown. Mr K had described high levels of anxiety in relation to open prisons due to previous abuse from inmates. Mr K was keen to be released on licence to an approved premises to access help and support from workers, friends and family and felt that this support would help him to recognise the signs if he were to become depressed again. Mr K described support from the church and god, commenting that he had been informed there was a "very nice church" in Guildford that he could attend and where he would fit in. Dr R's view was that Mr K had a predominant diagnosis of personality disorder complicated by clear episodes of depression with "prominent anxiety symptoms". Dr R reiterated his view that Mr K was not suitable for detention under the Mental Health Act and that although Mr K would prefer to move to an open prison, Dr R felt that this was neither necessary nor appropriate. Dr R stated that Mr K was keen and motivated to engage with mental health services and other assessments and treatment that might be offered. Dr R recommended that on release Mr K be under the care of a community forensic team where he could benefit from input from a consultant forensic psychiatrist, psychiatric nurse and possibly a social

worker. Dr R confirmed that if Mr K were to be placed in Brighton his colleague would offer an assessment with a view to taking Mr K onto his caseload. However if Mr K were to be placed in Guildford or elsewhere in the country, Mr K would need to be referred to the relevant local service for their input.

4.17 In September 2013 a report completed by Mr J, an offender manager in Surrey and Sussex Probation Trust, indicated that Mr J remained of the opinion that Mr K's risk factors needed to be tested in an open prison environment prior to release into the community on licence. It was Mr J's view that Mr K needed to demonstrate he had capacity to manage his risk factors in a less restrictive environment and to have a gradual re-integration into the community before release could be considered.

4.18 Also in September Mr D, an offender manager at HMP Maidstone completed an addendum report indicating that there was nothing further that he could add to his report of June because he had not seen Mr K for two months. The reason for this was because Mr K had been moved to HMP Whatton. Mr D's earlier report indicated that "given [Dr B's, the independent psychiatrist] conclusion and recommendations of admission to medium secure psychiatric hospital, I find myself at difficulty to suggest an alternative, although I am unsure whether [Dr M1's] report now rules out this possibility. I would expect Mr K to relish the opportunity of progressing from closed conditions, to any option. However this is not the case and therefore leads me to consider that he should be better prepared for this."

4.19 On 24 October Dr R wrote to Mr K's GP to provide a summary of the meeting that he and Mr E, mental health nurse, had held with Mr K at his approved premises on 22 October. Dr R noted Mr K's diagnoses as recurrent depressive disorder (currently in remission), and personality disorder, mixed types (emotionally unstable and antisocial types). Medication at that time was venlafaxine 75mg daily, simvastatin 40mg daily and aspirin 75mg daily. Dr R noted that Mr K had been released from prison on 21 October to Brighton approved premises and that his offender manager was Mr J. Dr R advised that Mr K was serving a life sentence for murder and had been released on licence after serving nearly 30 years in prison. Dr R provided brief details of Mr K's original index offence and advised that he had completed significant psychological treatment and that he had three previous failed attempts in open conditions. Mr K had reported that he was feeling okay and "chilled out" following release from prison and indicated that his faith was helping him to manage. Mr K had indicated he was keen to have some support from mental health services but that he was wary of seeing a psychologist because he had previously had some bad experiences. Mr K was due to be assessed by Langley House Trust[18] and that supported accommodation might be offered. Mr K was concerned about this because he understood that Langley House didn't have any accommodation in Sussex and the nearest accommodation was in Kent. Despite exclusion zones in Hastings, Eastbourne and Rye, Mr K

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[18] Langley House Trust is a Christian charity that provides specialist housing, programmes and support services in the community, and targeted advice in prisons, for people seeking to live crime-free. www.langleyhousetrust.org

was keen to remain in Sussex because he had friends and support. Dr R noted that although it was early days, Mr K appeared to have managed the transition from prison to the community and that the immediate risk factors were self harm and suicide, noting this was a chronic long term risk given his history of attempted suicide and his family history of completed suicide. Dr R advised that risks to others would be a concern when Mr K started an intimate relationship. It was unclear what mental health support Mr K needed at that time, but Dr R felt it was appropriate that Mr K was in the care and treatment of the community forensic team in the first instance. Dr R advised that Mr K would initially have weekly support from Mr E and a psychiatric review every "few weeks or month". Dr R advised that he had agreed with a colleague who covered Brighton that he (Dr R) would continue to follow up Mr K in the community. Dr R indicated that psychology input was of "paramount importance" and that he would discuss with his colleagues whether this could be arranged.

4.20 Dr R later sent a letter to Mr K inviting him to attend an appointment with him and Mr E on 11 November. This was followed up the following day with a further letter advising that an appointment with Mr E had been arranged for 5 November.

4.21 The appointment on 5 November took place at Mr K's approved premises. Mr E noted that Mr K was on time and dressed in smart casual clothing. Mr K presented with no evidence of psychosis or depression and stated that all was "good". Mr K described an incident in the hostel when he had established that a new arrival at the hostel had been married to a cousin of Mr K and had abused Mr K's sisters. Mr K said that it didn't cause an adverse incident as he had forgiven the man "using his Christianity". Mr E noted that the hostel had subsequently moved the other man to another hostel. Mr K reported that hostel staff were very supportive and that he was keen to attend church, but that the probation service needed the contact details of somebody in the church before he could attend. Mr K reported being busy with friends and relatives and "things to do".

4.22 On 12 November Dr R wrote to Mr K's GP to provide a summary of the appointment he had with Mr K the previous day. Dr R noted Mr K's diagnoses as personality disorder, mixed types (anxious, emotionally unstable and dissocial traits) and recurrent depressive disorder, currently in remission. Dr R repeated the information about Mr K's recent release from prison following a long sentence and that Mr K was in contact with his probation officer, Mr J, on a weekly basis. Dr R advised about Mr K's exclusions zones: Eastbourne, Hastings and Bexhill and noted that Mr K had family that lived in Bexhill. Dr R noted that the immediate concern was a recurrence of depression and advised that Mr K had made a "serious suicide attempt" when he had been in an open prison in 2010. Dr R indicated that should Mr K start a relationship a disclosure would need to be made and that Mr K would need further help and support. Dr R advised that he was in charge of Mr K's care, with support to Mr K being provided by Mr E, a community psychiatric nurse. Dr R also advised that the Trust had identified a forensic psychologist, Dr M2, who would meet with Mr K and "hopefully offer him some help and support".

Mr K's mental health needs were still unclear and that this was further complicated by the fact that Mr K's placement in the approved premises was only temporary and that longer term supported housing was being sought. Mr K was sharing a room at the approved premises and was finding this difficult causing paranoid thoughts. Mr K reported that he was reading the bible a lot and spoke about how people have God's voice in their mind, describing this as a "small, little voice". He also said he wished to be baptised. Mr K told Dr R that staff at the approved premises were concerned that Mr K was spending too much money, however Mr K said that he had no clothes and had more money than he thought. Dr R noted that Mr J and staff at the approved premises had told Mr K that they felt he was doing too much and that he needed to "slow down". Mr K said that he had accepted this and would try. Mr K was keen to see Mr M2, a consultant forensic psychologist and that he wanted to continue with weekly appointments with Mr E. Dr R noted that he thought that Mr E would not be able to commit to weekly appointments, but thought that he would be able to see Mr K every two weeks. Dr R advised that he would see Mr K next on 9 December.

4.23 Mr E completed a Level One risk assessment[19] following this appointment. Risks at that time were noted as risks from others/vulnerability. The risk management plan was noted as:

- "is on life sentence";
- "has a probation officer (supervisor);
- "has conditions of licence";
- "has an exclusion zone";
- "is on Care Programme Approach";
- "seen by forensic community mental health team".

4.24 The question about whether a Level Two risk assessment[20] was required was marked as "unknown". However a level two risk assessment was completed on 14 November but this assessment did not note any contributors other than Mr E. Four present risks were noted as unknown: suicide, risk to others, substance misuse, and risk to children. There is little information in this risk assessment that was not included in the level one risk assessment and both risk assessments noted that it was unknown whether the service user had been involved in the risk assessment. Mr E did note that any change in the presentation of Mr K's risk should be discussed with the community mental

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[19] Level One risk assessment: comprehensive risk assessment and management plans can be completed by a single practitioner but where there is multidisciplinary (MDT) or multiagency input into the assessment or plan, this must be documented. Sussex Partnership NHS Foundation Trust Clinical Risk Assessment Management Policy & Procedure, ratified January 2012

[20] A Level Two risk assessment should be completed by a multi-disciplinary team, or multi-agency professionals. Sussex Partnership Trust Clinical Risk Assessment and Management Policy and Procedure, ratified January 2012.

health team, Mr J (Mr K's probation officer), and MAPPA should be informed as a matter of urgency.

4.25 On 15 November Mr E wrote to Mr K to inform him of an appointment on 26 November. Mr K attended this appointment which took place at the approved premises. Mr K reported experiencing some anxiety but advised that he was coping with it well. Mr K showed Mr E some art work that he had painted and that he hoped to "paint an autobiography". Mr K spoke about obtaining a sick note, which he felt might relieve pressure for a short while regarding the job centre. Mr K believed he was waiting to be interviewed for a placement in a CRI hostel[21]. Mr E spoke to hostel staff who reported no issues or concerns and Mr E arranged to see Mr K again three to four weeks later.

4.26 On 3 December Mr M2, the consultant forensic psychologist, visited Mr K at the approved premises. Mr M2 discussed the adjustment to living in the community and noted that Mr K was involved with the local church and that he seemed "confident, perhaps over-confident" about his ability to adjust to his new life. Mr K talked about his history of depression and Mr M2 noted that Mr K was prescribed venlafaxine and was happy to take this long term.

4.27 Mr M2 saw Mr K again on 10 December at the approved premises. Mr K reported having difficulties with benefits the previous day and felt that he had been bullied. Mr K said he had a "fleeting thought" of drinking strong beer on the beach but had resisted the temptation. Mr M2 talked about risk and Mr K indicated he felt he was only a risk to himself but not to others, except when a relationship ended. Mr K said that he was not in a relationship or contemplating one so felt that this was not relevant. Mr M2 discussed family relationships and Mr K said that his sister might visit him in the new year. Mr K reported that he did not envisage that he would be at risk of being returned to prison. Mr K talked briefly about his wish to dress in female clothing. Approved premises staff mentioned that Mr K was often taking to staff and appeared quite needy. Mr M2 noted that Mr K's presentation was pleasant but "mildly narcisstic", however it was positive that he had been able to negotiate with the benefits agency.

4.28 On 6 December Mr E wrote to Mr K with details of an appointment on 31 December. This appointment took place at the approved premises and Mr E noted that Mr K appeared relaxed and polite and reported no problems. Mr K spoke about the issues he had experienced with the job centre and described handling and coping with this well. Mr K told Mr E that he felt he didn't really need psychology and described feeling tricked about talking to a psychologist in the past. Mr E advised that the service was only interested in helping Mr K and that there were no hidden agendas, the aim was to keep Mr K well and out of prison. Mr K said he was due to see his probation officer soon and that he had not heard about being assessed for housing. Mr K said he would discuss this with his probation officer. Mr K reported continuing to take the

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[21] CRI (Crime Reduction Initiative) hostel – we have not been able to establish any more information about the provision of this service

antidepressant medication and that he had no problems that Mr E could help with.

2014

4.29 On 3 January Mr E wrote to Mr K with details of an appointment on 31 January. We can find no records of this appointment taking place or being subsequently cancelled or amended.

4.30 On 22 January Mr M2 completed a psychological report noting that Mr K had been referred for assessment to determine "whether psychological intervention was required by the secure and forensic team". Mr M2 noted that he had seen Mr K on two occasions and that because there was significant information already in Mr K's records, Dr M2 had not taken a structured history. Mr K had talked about the original index offence which he had described as "horrendous" but said that he felt he was not an antisocial person generally and that he did not think of himself as a sex offender. Mr K had said that he was coping okay but had been somewhat depressed just prior to Mr M2's visits. He associated this with the anniversary of the death of his mother. Mr K also told Mr M2 that he had discovered that his cousin had been murdered in a recent local incident. Mr K reported that he was seeing his probation supervisor once a week and that the number of "sign-in times" had been reduced within three weeks of his arrival in Brighton. Mr K described surpassing what was expected of him on release from prison. Mr K said that he had drunk little alcohol since being in the community and that he had a "liberal attitude" to cannabis but found that it always made him paranoid. Mr K appeared ambivalent about the prospect of psychotherapy or counselling, expressing concern about the resources it might take up. Dr M2 expressed a view that that it was unlikely that therapy would be of any benefit without Mr K's willing participation. Dr M2 stated that there was nothing in his interview to "raise specific concerns about risk, although this area was not assessed specifically". Dr M2 indicated that it seemed that Mr K had an overly optimistic and minimising view of the process of rehabilitation and Dr M2 "wondered how he might react if he had a serious reverse".

4.31 A week after this report (on 28 January) Mr E noted that Mr K had been reduced to MAPPA level 2 from MAPPA level 3. This information was provided to Mr E by the Trust MAPPA Level 2 meeting representative for Brighton but was not recorded in Mr K's record by this individual.

4.32 Mr K's next contact with the Trust was on 3 March when he was seen by Dr R at Hove Polyclinic. The appointment had been arranged in response to concerns expressed by hostel staff and a summary of the appointment was sent to Mr K's GP on 10 March. (We cannot find any evidence that this letter was also sent to Mr K's probation officer, as was usually the case with Dr R's letters). It appeared that Mr K had been talking more about his sexuality and had been wearing a dress. Mr E had recently been on sick leave so had not seen Mr K for some time and Mr K had missed his last appointment with Dr R. Mr K reported to Dr R that he was "alright" and that he had experienced "a few moments" since Dr R had last seen him. Mr K was still at the bail hostel (and had been for four months) and had understood the plan was for him to move

to supported housing, however at interview with the housing department they had talked about Mr K going to a bed and breakfast. Mr K said that his probation officer had "said nothing". Mr K reported that he had started to become paranoid and thought that he was being set up to fail. Mr K said that the hostel could be manic and noisy at times and he would often go out all day and find a café to have a "quiet cup of tea". Mr K said that he was worried about being placed in a bedsit and on the day he felt quite depressed he had gone to the seafront and started thinking about going to Beachy Head, but knew that he could not because of his licence conditions. Mr K admitted to feeling suicidal on that day and that since he had only felt a "little sad". Mr K expressed concern about sharing this information with Dr R because he was worried that he might be recalled to prison. Mr K described most of his stressors being about accommodation and that he was really looking forward to having his own place. Mr K admitted to missing one dose of venlafaxine but that he knew if he had missed a dose because he would start to feel jerky and panicky. Mr K told Dr R that he had been to an interview for a place at the CRI but had been turned down; Mr K felt he had been too honest. Mr K reported that he had not started any intimate relationships and that he was not intending to do so. Dr R noted that Mr K had done a picture of a man sitting on the edge of Beachy Head and that he had appeared worried that Dr R had seen the picture. Mr K was due to attend a music group at the church on the evening of his appointment with Dr R and spoke about buying a guitar. Mr K told Dr R about his new probation officer, saying that he had met her and she seemed "fine". Mr K's understanding was that she would only be his probation officer for one month and that he would then be allocated another probation officer. Dr R concluded by noting that he had not found any major changes in Mr K's mental health. He was concerned that Mr K had experienced a day when he felt suicidal but considering Mr K's history Dr R felt brief episodes such as that were to be expected. Concerns would be heightened if those episodes were to be sustained or long-standing. Dr R discussed the possibility of increasing Mr K's antidepressant medication but he declined. Dr R noted that Mr K's biggest hurdle was his new accommodation.

4.33 On 24 March Dr R's secretary wrote to Mr K to advise that his next appointment had been moved to 28 April because the original date given was Easter Monday. A subsequent letter was sent on 10 April to advise that the appointment needed to be changed again and a further date of 12 May was given.

4.34 On 11 April Mr E met with Mr K at the approved premises. Mr K reported he was moving on 14 April to a flat in Hove and that he was cooking breakfast for the staff at the approved premises as a goodbye. Mr E noted that Mr K presented as well although he spoke of periods of depression or anxiety. Mr K reported an incident where a man had approached him and asked him to perform a sexual act. Mr K reported this incident to Mr E and to staff at the approved premises whom also informed Mr E. Staff questioned why Mr K had been at the location if he did not want that kind of attention to which Mr K had replied that he had "problems with his sexuality". Mr K reported that he had met with Dr R who had advised that if Mr K had periods of depression, he

could increase his medication. Mr K had not found employment and "was in no hurry and not currently looking for work". Mr E advised that he would send Mr K a further appointment and that it would take place at Hove Polyclinic.

4.35 On 12 May Dr R made a file note indicating that he had met with Mr K who had "anxiety and paranoia" for 30 minutes and then realised he had missed medication for three days. Dr R noted that Mr K had talked freely, and had talked positively about his new flat. Mr K had reported that he had started dressing as a woman, to come to terms with his sexuality. Dr R's note indicates a three month review and query discharge.

4.36 On 15 May Mr E wrote to Mr K's new GP to advise that he and Dr R had seen Mr K on 12 May for an outpatient review appointment. Mr E noted that Mr K presented as very well and appeared relaxed. Mr K had discussed increasing the dose of venlafaxine (at that time the dose was 75mg daily) and wondered whether he could use it on a PRN basis. Mr E noted that Mr K had been advised to discuss any increase with his GP and was advised that venlafaxine was "not really a prn type medication". Mr E noted that he and Dr R had also discussed discharging Mr K to the care of his GP, as the plan had been for the community forensic team to "remain involved for a set period of time", and it was felt that now Mr K had secured his own accommodation the team would look to discharge him in three months' time.

4.37 We know that Mr K's case was moved to MAPPA level 1 in May 2014 because this fact was shared by the probation service and mentioned during interviews with staff. However there is no record of the change in MAPPA level in any of Mr K's clinical records held by the Trust.

4.38 On 29 May Dr R's secretary wrote to Mr K's GP noting "thank you for your letter of 22 May". There is no copy of this letter in Mr K's clinical records provided by the Trust. Dr R's secretary provided correspondence from Mr E and Dr R. With this letter there is an undated letter from Dr R "to whom it may concern" providing a brief summary of Mr K's release into the community and the fluctuation in his mental health during the period of transition from prison. Dr R noted that there had been a delay processing Mr K's application for ESA and Dr R confirmed that Mr K suffered from "very significant and enduring mental health problems" and that in Dr R's opinion Mr K was not fit to work.

4.39 On 1 July a Care Programme Approach care plan was "collated", it appears by Mr E. There was no change to any of the information when compared with the previous care plan dated November 2013. Crisis contact points were listed as Trust staff, Mr K's probation officer and "staff at the hostel". By this time Mr K was no longer living at the hostel and had moved into his own accommodation.

4.40 On 4 August Dr R reviewed Mr K at Mr K's request. A summary of the appointment was sent to Mr K's GP on 12 August. Mr K had called Dr R "saying he wanted a chat", Mr K had reported a period of "quite low mood, where he was feeling suicidal" but he had spoken with a friend and recovered. Mr K said that he had a lot of stressors at the time, mainly financial because he had been turned down for PIP and was still waiting for ESA. Dr R noted

that when he had spoken to Mr K the previous week, he had suggested that Mr K increase the dose of venlafaxine from 150mg to 300 mg which Mr K reported he had done with good effect. Mr K reported feeling more settled and that he was getting to know his new probation officer. He had found the transition difficult because he had known Mr J quite well. Mr K reported that he had forgotten to eat during the recent period of low mood and that his self-care had deteriorated; he had not showered for a week having forgotten to do so. Mr K had attended the appointment with Dr R with Ms S who had been supporting him and Mr K reported that there was a possibility the relationship might develop in due course. Dr R considered that Mr K's mood appeared settled at that time, but noted he was vulnerable to episodes of low mood when stressors were present, such as lack of money. Dr R asked the GP to increase the dose of antidepressant medication on Mr K's repeat prescription and noted that he was going to see Mr K again on 1 September. Dr R also stated that although the team had been considering discharging Mr K from their caseload, it was Dr R's view that he should remain under their care for longer.

4.41 Dr R saw Mr K again on 1 September and provided a summary of this appointment to Mr K's GP on 11 September. Mr K had reported that his probation officer had been on leave and that he had seen the head of probation in her absence, and that this had been "okay". Mr K talked about his relationship with Miss S and said that they were becoming closer and would text each other every day. Mr K reported that the relationship had not become intimate but he could see it progressing that way in the future. Mr K said that he had discussed the relationship with his probation officer and that she had spoken to Miss S. Mr K reported that he was concerned about Miss S that day because he had sent her a text but she had not responded (it later transpired that Miss S had been unwell with a cold). Mr K said that he felt lonely and sad at times and struggled with motivation. He sometimes forgot to eat and was continuing to struggle financially because he still had not received his benefits. Mr K said that his friends had been lending him money, which had helped him. Mr K reported angry thoughts in his head but denied drinking alcohol because he could not afford it. Dr R noted that Mr K's mental state seemed settled, with no evidence of psychosis, suicidal or dangerous ideation. Dr R noted he had planned to see Mr K again on 13 October.

4.42 By the time this letter was sent Mr K had seriously assaulted Ms A and had been arrested.

5 Arising issues, comment and analysis

5.1 It is clear from the documents that we have read that there were different views held by clinicians about the appropriate pathway for Mr K when leaving prison. The two options being debated were:

- a return to the community on license through approved premises
- a move to a low secure psychiatric hospital

5.2 It is clear that there are different views held by Dr R and the Parole Board about what Dr R did and did not recommend at the Parole Board Hearing in October 2013. The decision by the Parole Board at that hearing was that Mr K should be released on life license.

5.3 It is noted in the confidential MAPPA Serious Case Review report that this decision was not supported by the Probation Service and that the decision was "recommended by the Consultant Psychiatrist, based on a proposal to accommodate [Mr K] in an approved premises with support from the Community Forensic Team".

5.4 The Parole Board Oral Hearing Decision Letter dated 2 October 2013 states:

"[Dr R] said that he disagreed with the opinion of [Dr B]; it would be wrong to send you to a secure hospital or for an assessment to take place there. [Dr R] said there were differing types of diagnoses but in your case it was principally a personality disorder with features of emotionally unstable type. He said that you also had some symptoms suggestive of a psychotic illness, but this was not sufficient to warrant a diagnosis. He said that you suffered from depression and this is not uncommon in people with a personality disorder. Your depression was well controlled by medication. [Dr R] said that what you needed was someone in whom you could confide and this would be more usefully provided by the psychological services that were available in the Brighton area near the Approved Premises; in his opinion the best solution would be for you spend [sic] initially a short period in Approved Premises and thereafter move to suitable accommodation such as that provided by the Langley House Trust. It would be better for you if you felt that you were being trusted by being released into the community."

5.5 It does appear that the Parole Board believed that Dr R was recommending that Mr K be released into the community. Although the MAPPA serious case review states:

"It is also clear from the MAPPA records that Sussex NHS Partnership Foundation Trust was supportive of the Level 3 panel's decision not to support [Mr K's] release."

5.6 This statement appears to support Dr R's position that he did not recommend Mr K's release into the community. It would seem unusual for Dr R to attend a MAPPA meeting where he indicated he did not support Mr K's release, only then to present a conflicting position to the Parole Board.

5.7 Dr R told us that he could recall attending the MAPPA meeting when Mr K's case was discussed prior to the Parole Board hearing. Dr R agreed that the Probation Service was in favour of supporting Dr B's recommendation that Mr K be admitted to a medium secure psychiatric unit and that the forensic psychiatric service did not support that view.

5.8 Dr R said that he had never believed, and still did not believe that Mr K had an underlying mental illness that required treatment or further assessment in hospital. When Dr R assessed Mr K whilst he was still at HMP Maidstone, he

discussed with Mr K the possibility of psychological therapy and Mr K said he would engage with psychology if he were released into the community.

5.9 Dr R told us very clearly that he had never given a view about whether Mr K should be released into the community. He told us that he was concerned that it had been wrongly recorded that he had supported release into the community and that he had never said "I think he is ready for release, I think he is ready to be discharged into the community". Dr R qualified this by saying that he would never have said this because it was not his job to do so.

5.10 Dr R was clear that he had told the Parole Board that if Mr K was released into the community, the forensic psychiatric service would provide care and treatment because Mr K did have some mental health difficulties and he had indicated he wanted to engage in psychological therapy.

Terms of Mr K's license

5.11 We have seen two versions of Mr K's licence conditions. One was included in the information provided to us by the Probation Service and formed part of the Parole Board Oral Hearing Decision Letter dated 4 October 2013. The other is a Licence signed on behalf of the Secretary of State on 16 October 2013 and signed by Mr K on 18 October 2013. The number of licence conditions in the Parole Board Oral Hearing Decision Letter is 10; the number of conditions in the Licence is 16. The additional conditions within the actual Licence refer specifically to the requirement to be supervised and monitored by his supervising officer, to undertake work only where it has been approved by his supervising officer, not to travel outside of the United Kingdom without the relevant prior permissions, and to be well behaved and not do anything to undermine the safety of the public.

5.12 The one condition that specifically related to his mental health care and treatment was present in both documents:

"You must attend all appointments arranged for you with a psychiatrist/ psychologist and/or medical practitioner and cooperate fully with any care or treatment that they recommend."

5.13 Dr R stated that his understanding was that the licence required Mr K to engage with mental health services and that there was nothing specific in there about psychology or attending psychology sessions. We asked Dr R whether he would have felt he could have had a conversation with Mr K along the lines of "are you aware your licence conditions actually say you need to cooperate with treatment we recommend and I'm recommending this…?". Dr R indicated this would have been difficult because for psychological treatment to be successful, the client needs to engage freely and openly and not feel coerced. Therefore Dr R would not have told Mr K that he had to see the psychologist because it would not be therapeutic or helpful.

5.14 Dr R said that in retrospect it was "very, very concerning" that Mr K had disengaged so quickly and that he hadn't engaged with psychology. He also

agreed that it was fair to highlight that the service had not considered what would happen if Mr K refused to engage.

5.15 It is our view that the team should have had a discussion about whether Mr K's refusal to engage in therapy was a breach of his licence conditions. This view is strengthened by the fact that Dr R's opinion was that psychological therapy was of paramount importance. However we also believe that Mr K's probation officer should have sought more information from Dr R in order to have a more complete view of Mr K's compliance with care or treatment recommendations. See recommendation 1.

Risk reduction

5.16 Mr K's clinical records clearly indicate that he was being treated by the community forensic service under the Risk Reduction category.

5.17 We were provided with the Operational Policy for the Forensic Community Outreach Service dated September 2014 as the relevant operational policy in place both at the time of the incident and currently. Given that Mr K was first taken on for treatment in October 2013 we asked to see a policy in place at that time but we were told that the team was unable to locate a policy prior to the 2014 policy that we were provided with. It is our understanding that there were a number of drafts of the 2014 policy and therefore we have based our assessment on the risk reduction section of the policy being referenced in 2013.

5.18 The policy states that the service "seeks to support other services to manage risk in their clients safely….by offering 'risk reduction' to service users where the risk of harm is judged to be high".

5.19 The policy states that referrals would be accepted for risk reduction work where the case was supervised by another agency and that the service user would not be subject to Care Programme Approach. The approach set out in the policy states that the service would provide a specialist assessment of the service user followed by a report detailing a risk formulation and recommendations for treatment and care. The policy also specifies that all service users would undergo risk assessment as per the Trust policy and following the community forensic service risk assessment guidelines.

5.20 It did not appear to us that there were clear expected outcomes for the risk reduction work with Mr K. We would have expected to see specific outcomes clearly linked to the interventions required to reduce Mr K's risks, both to the public and to himself. We would also have expected there to have been a more clearly documented relationship with Mr K's probation officer in order to monitor Mr K's compliance with the terms of his licence.

5.21 The community forensic service risk assessment guidelines indicate that a Level 1 assessment should be completed within seven days of the initial assessment and that a Level 3 assessment should be completed within a further 14 days. A Level 3 risk assessment is described in the guidance as:

"*Level 3 risk assessments are offence specific assessments which help inform the risk formulation. The service will use the most clinically appropriate tool for the service user.

For violent (non sexual) offences the service uses the HCR-V3 with scenario planning and risk reduction and/or VRS.

For sexual offenders the service uses the SVR-20 or RSVP or VRS-SO."

5.22 It was unclear within the policy how the team members should measure the effectiveness of their risk reduction treatment plan. We discussed this with Dr R who agreed that the policy was not specific about this.

5.23 Dr R agreed that an HCR-20 had not been completed at the time and acknowledged that this was a "fair point". Dr R told us that current practice is that every patient has an HCR-20 regardless of whether they are on risk reduction or standard caseload.

5.24 Had an HCR 20 been completed at the outset of the risk reduction work with Mr K, this would have included realistic formulation and scenario planning that would then have informed the risk management plans for Mr K. However, this would not have helped inform the clinical team of the changes to Mr K's risks over short periods of time. The CFS should review other risk instruments that work over shorter time periods.

5.25 We understand that the current operational policy for the community forensic service is being reviewed and we suggest that the use of appropriate risk instruments that are effective in monitoring risks over short periods of time is included in the revised version. See Recommendation 2.

5.26 We would have expected the service to have a clear plan of the therapeutic interventions required that would reduce Mr K's risks. It appears that the view at the time was that because Mr K was on the risk reduction care pathway, there was less of a focus on monitoring and managing his risks in a structured way. This feels counterintuitive to the whole purpose of the risk reduction pathway that was, as the title suggests, to reduce risk. See Recommendation 3.

Care Programme Approach

5.27 Dr R told us that Mr K's care and treatment was managed under Care Programme Approach and that his usual working assumption was that every client under the care of the community forensic service would be on enhanced Care Programme Approach.

5.28 Dr R told the internal investigation team that it was his understanding that a clients' care coordinator was responsible for completing the Care Programme Approach paperwork. Dr R confirmed to us that this remained his understanding.

5.29 It appeared from Mr K's records that no Care Programme Approach meetings were held between October 2013 and September 2014. Dr R told us that he understood that the meetings that he and Mr E held with Mr K were Care Programme Approach review meetings. However he realised that in his subsequent correspondence he had never referred to them as such and that if it were a Care Programme Approach review meeting then the service should have invited Mr K's GP and the Probation Service. Dr R confirmed it would be the care coordinator's job to set up Care Programme Approach reviews and meetings.

5.30 Mr E was unable to confirm or deny that Mr K was under Care Programme Approach. However he told us that the process for updating care plans at the time was that it was done as a team and that information from team members, Dr R and Mr K would have been used to inform care plans.

5.31 The policy in place at the time stated that clients on the risk reduction pathway "will not be subject to Care Programme Approach" and would be managed by a single clinician. This was not the case for Mr K, because both Dr R and Mr E were involved in managing Mr K's care and treatment.

5.32 The same policy also states that cases requiring medical review would be seen within the service and "accepted for case management". The implication of this being that if a doctor was involved in the care and treatment, the client would be on the case management pathway. It is our view that this was the cause of some confusion about how/whether or not Mr K was subject to Care Programme Approach. We suggest that the operational policy for the community forensic service is reviewed so that it is clear about who should or should not be on Care Programme Approach. See Recommendation 4.

Care and treatment

5.33 Dr R noted in October 2013 that it was unclear what mental health support Mr K required when he was released from prison. Mr E told us that he considered that Mr K's mental health was stable at that time and that he didn't feel that Mr K needed any specific mental health intervention.

5.34 Mr E was unable to indicate whether or not it was clear to him what support Mr K needed when Mr E was first allocated as the care coordinator, other than the team was working with Mr K under "risk reduction". Mr E clarified his understanding that this meant that the Trust was not the lead agency and that the Trust was working alongside another agency that "supposedly takes full responsibility or is the lead agency".

5.35 Mr E said that at the time when Mr K moved from the approved premises he had indicated that he was suffering "a bit from depression", however Mr E's recollection was that Mr K did not want his antidepressants increased at that time.

5.36 We discussed with Dr R what the service had planned for Mr K's care and treatment. Dr R stated that the initial plan was that the team would provide

psychiatric support to deal with Mr K's recurrent depressive difficulties and problems, monitor his risk of suicide and provide psychological therapy.

Psychological therapy

5.37 Dr R's view is that Mr K is an articulate, intelligent man who had undergone a significant amount of psychological therapy in the past. Dr R said that Mr K always presented well at interview and that in retrospect this could have impacted on the way in which Mr K communicated with professionals, leading to false or over-assurance of Mr K's wellbeing and level of risk.

5.38 Dr R's assessment of Mr K prior to release from prison was that psychological therapy was of "paramount importance" and at that time Mr K had indicated he was willing to engage in psychological therapy. For the "risk reduction" work to have been successful, it is the psychological therapy that was crucial as Mr K's highest risk was related to his personality disorder.

5.39 Mr M2, the psychological therapist, saw Mr K twice in December 2013 at Dr R's request to assess "whether psychological intervention was required". Mr M2 completed a brief report on the outcome of the assessment on 22 January 2014.

5.40 Dr M2 advised "there was nothing in my interview to raise specific concerns about risk although this area was not assessed specifically". Dr M2 noted that Mr K was concerned about the resources he might take up if he engaged in psychotherapy or counselling. Therefore Dr M2 left it for Mr K to consider the matter and get back to Dr M2 via his community nurse, Mr E. Dr M2 noted that any psychotherapeutic approach would not be of benefit without Mr K's willing participation and therefore advised that he (Dr M2) would take no further action at that time. Dr M2 concluded that Mr K "had a somewhat overly optimistic and minimising view" of the process of rehabilitation and Dr M2 "wondered how [Mr K] might react if he had a serious reverse". There does not appear to have been any consideration about the management of Mr K's risk to others.

5.41 As we have indicated earlier, it was Dr R's view that it would not have been possible to force Mr K to engage in psychological therapy whilst in the community. It is for this reason that Dr R did not consider escalating the issue when Mr K did not engage with Dr M2. Dr R reiterated that he provided full and detailed information to Mr K's probation officer and that if there had been information that was of concern, he would have expected Mr K's probation officer to contact him. However the only communication we can see from Dr R following the psychological therapy assessment is a letter to Mr K's GP on 10 March. We can see that Dr R usually copied his letters to Mr K's probation officer, however that was not the case with the letter on 10 March. It therefore appears that the probation officer was unaware that Mr K had:

- refused to engage in psychological therapy;
- missed an appointment with Dr R;

- admitted to missing one dose of his medication.

5.42 We have set out our views on the importance of compliance with psychological therapy in Mr K's treatment plan in paragraph 5.15 above.

Assignment of clinical staff

5.43 Mr K moved into approved premises in Brighton and Dr R told us that his colleague, Dr A was (and continues to be) the consultant covering the Brighton area. It was Dr R's original view that Dr A would therefore be the consultant responsible for Mr K's care and treatment.

5.44 However, Dr R told us that following discussion with Dr A it was agreed that Dr R would be the responsible consultant. Dr R said that this decision was made because Dr A had no knowledge of Mr K whereas Dr R did have some knowledge of Mr K, having assessed him on previous occasions. It was felt that it would provide better continuity for Mr K for Dr R to take responsibility for his care and treatment.

5.45 Dr R said that Mr K's care coordinator (Mr E) was allocated from within Dr A's team and that he (Dr R) had not worked with a client with Mr E previously. Dr R told us that his usual experience of working with community nurses is that they were generally more risk averse than Dr R, however in this case he felt that he was more risk averse than Mr E. However, Dr R felt that Mr E had a lot of knowledge about Brighton, the approved premises and had a good relationship with the staff there and Dr R thought this was a "very good" thing.

5.46 On reflection, Dr R told us that allocating staff from different teams "probably wasn't a good idea", because it meant staff did not understand each other's ways of working. Although the teams met every week to discuss cases Dr R agreed that (with the benefit of hindsight) the lack of regular close working with Mr K resulted in periods of time when Mr K had no contact from the service.

5.47 Although we understand that both Dr R and Mr E were based in the same building, they both spent the majority of their clinical time working either on the ward (for Dr R) or in their allocated communities.

5.48 It does appear that the allocation of Mr K to a consultant based in the east of Sussex with a care co-ordinator based in the west of Sussex was an exception. We have heard that the decision was made with the best of intentions towards Mr K (providing continuity from a consultant that he had met previously). However it is clear that there were unintended consequences: different ways of working between the consultant and care co-ordinator; lack of general clinical continuity and oversight. And these led to periods of time when Mr K was not being seen frequently by any clinician. See Recommendation 5.

Care coordination

5.49 There were a number of weeks when Mr E was not at work for extended periods of time. Management of Mr K's care and treatment was not allocated to another member of staff and consequently there was no active oversight of Mr K's presentation for a number of weeks.

5.50 Taking into consideration the fact that Mr K's consultant psychiatrist was not based within the team either, this left a high risk client with no active input from the service.

5.51 Mr E's caseload should have been reviewed during his absence and appropriate arrangements put into place for the clients on his caseload to receive suitable oversight and support. See Recommendation 6.

Contact with the police

5.52 We can see no evidence of any contact by Trust staff with the police. This does not cause us concern however, because there is no evidence of Trust staff being in possession of information that should have resulted in contact with the police.

6 Internal investigation and action plan

6.1 There were no terms of reference set for the internal investigation. The internal investigation report states that the team reviewed Mr K's contact with mental health services from 4 May 2012, when Mr K was referred to the Secure and Forensic Service, until his remand in custody after the incident on 10 September 2014.

6.2 The internal investigation team comprised:

- Consultant Clinical Psychologist #1
- Consultant Clinical Psychologist #2
- Consultant Psychiatrist
- Service Director, Secure and Forensic Services
- Managing Director, Adult Mental Health Services

6.3 The lead investigator was a Consultant Clinical Psychologist who was provided with oversight and supervision from her manager because this was the first investigation of this nature she had undertaken for the Trust.

6.4 The investigation team conducted one face to face interview and five telephone interviews with Trust members of staff and staff from the probation service. The team also reviewed clinical records held by the Trust.

6.5 The chronology developed by the internal investigation team highlighted a number of occasions when discussions or actions were not recorded in either paper records or on the electronic records system. There were three care or service delivery problems that the internal investigation found:

- Formulation of risk to others, including formulation of the index offence and a dynamic formulation of the interactions between risk indicators was not fully elaborated, and potential risk to others was under-estimated.
- All reports not available on eCPA and paper notes kept separately.
- Risk assessment and Care Programme Approach documentation inconsistent and/or incomplete.

6.6 There were five recommendations:

R1 To ensure that in cases with similar levels of complexity and risk, there is a comprehensive multidisciplinary and multi-agency assessment of risk, resulting in a dynamic risk formulation that includes a formulation of the index offence and identifies the dynamic relationship between risk factors and the actions to be taken when risk indicators emerge. Risk assessments and risk management plans to be shared across all agencies, including GPs.

R2 There should be a review of how decisions made by MAPPA are communicated with clinicians working with the patient (and *vice versa*) and how these inform the risk assessment and risk management plans, and how they are recorded in case notes.

R3 Secure & Forensic Service leadership to ensure that systems are in place for all reports and paperwork to be uploaded on eCPA.

R4 Secure & Forensic Service leadership to remind staff of the importance of completing all paperwork (especially risk assessment documentation, care plans and case notes) accurately, consistently and on time.

R5 Secure & Forensic Service to liaise with the Probation Service to ensure that there is information-sharing and joint learning about this incident.

6.7 The initial findings were discussed at a minuted meeting held on 15 October 2014 that was attended by most of the internal investigation team. The meeting identified some further actions and noted that the draft report should be provided by 22 October.

6.8 The final report was signed off by the Clinical Director on 5 November 2014 but the sign-off process was not completed until 19 December 2014. It is unclear why there was a delay.

6.9 We agree with these recommendations. We do feel that the splitting of Risk Reduction caseload from normal caseload management was relevant in this incident. We discussed the issue with the lead investigator who stated that she had raised the matter with the Service Clinical Director and Dr R. However, this did not lead to her making a recommendation.

6.10 We have discussed the issue at paragraphs 5.16 to 5.16 and have made associated recommendations (Recommendations 2, 3 and 4 refer).

Analysis of Trust action plan

6.11 The Trust provided us with a copy of the action plan and information to support the progress the organisation has made with these recommendations:

R1 The Trust has stated that the probation risk assessment document (OASys) now must be included at the point of referral to the community forensic team. We have seen a copy of the Referral Checklist and can see that the OASys risk assessment is mentioned, along with the HCR-20, PCL-R, START, RSVP assessments. The form indicates that the absence of "adequate information may result in the referral being held up" because the service "would not be able to effectively process the referral" without the information.

An audit of health records completed by the Trust in Quarter 3 2015-16 reviewed a sample of 29 forensic healthcare records; 25 of which were inpatient records and 4 were community records. The audit looked at both the presence and quality of clinical records. This found that the forensic service (both community and inpatient) had very high compliance with the standards; ranging from 95% to 98% compliant.

R2 In liaison with MAPPA the Trust has reviewed how decisions made by MAPPA are communicated with clinicians working with the patient. In December 2014 staff were advised via email to ensure that for every MAPPA meeting they attend, they record:

- Date of the meeting;
- MAPPA level and any change;
- Current risk/s and management arrangements;
- Outcome of the MAPPA discussion and any actions for Trust staff.

We have spoken to one Forensic Senior Practitioner about how effective the change has been in ensuring up to date and relevant information is available. She advised that she has implemented the guidance however it has not been written in to any policy or process. We recommend that the guidance is included in the relevant policy to ensure that expectations are clear. Recommendation 7.

R3 The Trust provided information about a completed audit looking at data for Quarter 4 2016-17 (January to March 2017). The audit assessed four components

- **Audit 1**: Trustwide Audit of Data Completion on Carenotes
- **Audit 2**: Audit of the Quality of Inpatient Services Paper Records
- **Audit 3**: Audit of the Quality of Community Services electronic Records
- **Audit 4**: Paper Health Records Tracking Audit

Audits 1 and 3 were relevant to Recommendation 3. Audit 1 found that the community forensic teams were only 59% compliant with the disability standard, and only 61% compliant with risk screening. This is of particular concern as management of risks in this client group is so important. Improvements noted for 2016/17 states that no action plan for forensic services was required because the service no longer uses paper records.

Audit 3 reviewed ten case records for the community forensic teams and found that overall the teams were 84% compliant with the audit standards.

R4 An email was circulated to clinical staff reminding them of the importance of completing paperwork accurately and in a timely fashion. However we have not seen any evidence that the Trust has audited the impact of the communication. If no audit has taken place then we would recommend that the Trust completes this in order to assure itself that practice has improved.

R5 The Trust informed the MAPPA Strategic Management Board of the actions being taken following the incident and took part in the serious case review undertaken by MAPPA. In September 2016 the MAPPA review had not concluded and therefore any learning had not been shared with the team at that point.

We have seen the serious case review report and can confirm that the Trust did indeed participate in that review, including by submitting an individual management review (detailed chronology). However, it is unclear from the information we have seen, what joint learning has taken place across the Trust and the probation service.

6.12 The findings of the report were a "Report and Learn Event" that was held on 10 December 2014, presented by the lead investigator. All clinical staff in community forensic service were encouraged to attend. We can see from the sign-in sheet that ten staff attended, however neither Dr R nor Mr E attended.

6.13 The lead investigator told us that the intention was to provide Dr R and Mr E with individual feedback at a face-to-face meeting prior to the learning event

on 10 December. However, this was not possible because of diary commitments and therefore a conference call was arranged for 26 November. The lead investigator advised that her recollection was that Mr E did not join the conference call.

6.14 Mr E told us he was given a copy of the report but that he "didn't sit down with anyone" and that he didn't attend a team wide meeting. It is not clear why Mr E did not dial in to the conference call or attend the learning event.

6.15 It is good practice to ensure that all clinicians involved in a serious incident received structured feedback about the learning from an investigation. We recommend that the Trust implements a system to ensure that this happens in future. See recommendation 8.

Clinical Commissioning Group oversight

6.16 Although this independent investigation follows the NHS England Serious Incident Framework (March 2015), the original serious incident investigation preceded the introduction of the March 2016 framework. In the previous framework, the arrangements in place for oversight and assurance were different. At the time Brighton and Hove Clinical Commissioning Group was responsible for initial scrutiny of the serious incident report. This took place and comments were forwarded to NHS England, in accordance with the policy in place at the time. At that time, it was not in the remit of the Clinical Commissioning Group to share any formal feedback with the Trust.

6.17 In the case of the internal investigation into Mr K'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.

6.18 On 15 January 2015 (127 days after the incident) the Serious Incidents Scrutiny Group met to discuss the incident. The overall purpose of the Serious Incidents Scrutiny Group was to agree closure of all serious incidents reported by organisations providing services commissioned by clinical commissioning groups across Surrey and Sussex. All serious incidents were referred to the relevant NHS England Area Team for final agreement before being closed.

6.19 Following the meeting the comments about the investigation were forwarded to the NHS England Area Team for final approval and closure. At this meeting the group noted that the contributory factors, "whilst could not be identified as a root cause, could not be ruled out either".

6.20 Although the incident related to a Brighton and Hove patient, responsibility for monitoring progress of the Trust actions sat with Coastal West Sussex as the lead commissioner.

6.21 We have seen no evidence that Coastal West Sussex Clinical Commissioning Group monitored progress of the action plan. See Recommendation 10.

7 Communication with affected parties

7.1 The Trust was responsible for conducting a Mental Health Act Assessment for Mr K after the incident. However, there was no further contact with him regarding the serious incident investigation. This is discussed further in paragraph 7.4 onwards.

7.2 The Trust had no contact details for any family members for Mr K. Both his parents had died some time before the Trust became responsible for Mr K's care and treatment.

7.3 The Trust had no further contact with the victim. The Trust contacted the police who stated that the Trust could not contact the victim.

Duty of Candour

7.4 The Care Quality Commission Regulation 20: Duty of Candour was introduced in April 2015 and is also a contractual requirement in the NHS Standard Contract. This was after the incident took place and the Trust had no contact with either the perpetrator or the victim regarding the serious incident investigation.

7.5 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."

7.6 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."

7.7 As we have stated above the Duty of Candour Regulations did not apply at the time of this incident and therefore the Trust had no duty to contact either the Mr K or his victim. However, it would have been good practice to have

made contact with Mr K to inform him that a serious incident investigation was being undertaken.

7.8 The advice from the police regarding contact with the victim concerns us greatly. The victim had only recently been discharged from Trust services and remains adversely affected by the lack of support they received after the incident. We would strongly recommend that the Trust and the police work together, under the remit of the Safeguarding Adults Board if necessary, to ensure that appropriate contact takes place with victims or their family following a serious incident. See our Recommendation 9.

8 Overall analysis and recommendations

Predictability

8.1 Predictability is "the quality of being regarded as likely to happen, as behaviour or an event".[22] An essential characteristic of risk assessments is that they involve estimating a probability. If a serious assault 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.[23]

8.2 Dr R told us that when he saw Mr K four days prior to the attack in September 2014, he found Mr K to be "not hugely different" from his previous assessment of him. Dr R told us that Mr K spoke of things that concerned Dr R but also that Mr K spoke of positive things too. Dr R told us that he was not aware of the fact that Mr K had been seen in a "gay cruising area". Dr R had asked Mr K about his lifestyle and Mr K had denied doing "anything like that".

8.3 Dr R was clear that in his view Mr K's biggest risk was of committing suicide and he (Dr R) was watching for signs of this risk increasing. But Dr R told us that he considered Mr K's level of risk to others would always be "at least medium or high in the long term".

8.4 Mr K was not always completely open and honest with Dr R or Mr E. We do not know the detail of what information Mr K's probation officer had, but we agree with Dr R's assessment that communication from probation to the Trust could have been better. Dr R provided detailed letters to Mr K's probation officer but we can see no evidence of any proactive communication from the probation service to Dr R. Dr R did acknowledge that the probation service "might have been falsely reassured by my letters" because although Mr K was engaging with the community forensic service, he didn't fully engage. Mr K missed appointments and refused to engage in psychological therapy.

8.5 It is our view that Mr K's lack of engagement is likely to be attributed to his personality disorder. He was well aware of what was expected of him as regards to his licence conditions. Had he had consistent contact from a care

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[22] http://dictionary.reference.com/browse/predictability

[23] 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

coordinator, this would have provided an opportunity to address the issue of his compliance with the mental health aspects of the terms of his licence. As we have discussed elsewhere, Mr E did not see Mr K as often as Dr R recommended when Mr K was released into the community, but neither was an alternative care coordinator allocated when Mr E was on sick leave. This resulted in many weeks going by without contact.

8.6 It is possible that more frequent oversight and more robust risk assessment and planning could have resulted in Mr K's increased risks being identified. However Dr R did see Mr K a few days prior to the assault and found no evidence that changed his view that Mr K's risk to others was medium to high.

8.7 It is therefore our opinion that whilst there was always a risk that Mr K would commit a further offence of a similar gravity to his original index offence, there was little in his presentation to indicate that this was any more likely in September 2014 than when he was first released from prison in October 2013. Clinical staff were not aware of Mr K's behaviours of cross dressing, going to gay areas, and engaging in risky sexual encounters. Had Mr K disclosed this information, we would expect that the clinical team would have reviewed Mr K's risk level. However Mr K told us that he chose not to disclose the information because he didn't trust his clinical team.

Preventability

8.8 Prevention[24] means to "stop or hinder something from happening, especially by advance planning or action" and implies "anticipatory counteraction"; therefore for a serious assault to have been preventable, there would have to be the knowledge, legal means and opportunity to stop the incident from occurring.

8.9 The Parole Board received a recommendation from Dr B in August 2012 that Mr K should be moved from closed prison conditions to a secure mental health unit. Dr R did not agree that Mr K would benefit from time in a secure mental health unit because he did not consider that Mr K had a diagnosis that warranted treatment in such a unit. We do feel that this difference of opinion should have prompted the Parole Board to have sought greater clarity about the views of the two psychiatrists before coming to a view about Mr K's route out of closed prison conditions.

8.10 Dr R was emphatic in his statement to us that he did not recommend to the parole board that Mr K be released into the community. Dr R was clear that he did not share Dr B's opinion that Mr K should be admitted to hospital because he could not see any benefit from further psychological assessment and treatment in a hospital setting.

8.11 Dr R said he told the Parole Board that any further psychological assessment, treatment and interventions could be done in the community provided that Mr K was motivated to engage. Dr R felt that Mr K was an appropriate client

[24] http://www.thefreedictionary.com/prevent

for the community forensic service and indicated to the parole board that the service could provide the interventions in the community. Dr R acknowledged that by making these statements to the Parole Board it could have been perceived that he was supporting release into the community. However Dr R was adamant that this was not the case and was keen to use the opportunity of talking with us to clarify his views.

8.12 We consider that Dr R's statement about Mr K's motivation to engage is key, because when Dr M2 assessed him it was Mr K's motivation that was lacking. Dr M2 left Mr K to discuss the matter with his community mental health nurse (also his care coordinator) but Mr E was off sick for an extended period of time and Mr K had not been allocated an alternative care coordinator.

8.13 We can see no evidence that Dr R shared Mr K's position with his probation officer. If there had been more effective communication between the probation service and the Trust, this issue may have been discussed and further consideration of the impact on Mr K's licence given.

8.14 We consider that the only action that could have been taken by the Trust that might have prevented the attack in September 2014 would have been for the Trust to have informed Mr K's probation officer that Mr K had refused to engage in psychology.

Recommendations

Recommendation 1

The Trust must ensure that when the terms of a client's criminal justice/probation licence to be in the community make reference to compliance with a treatment programme, clinical teams are clear about what actions could result in a breach of the terms, and how these should be reported. This will enable teams to report potential breaches appropriately.

Recommendation 2

The Trust must ensure that the operational policy for the community forensic service provides clarity about which risk assessments are required when working with a client under the 'Risk Reduction' pathway of the policy.

Recommendation 3

The Trust must ensure that when the 'Risk Reduction' pathway is being used to manage a client's care and treatment, the service has a clear plan of the intended outcome of the pathway, so that the therapeutic interventions intended to reduce the client's risks are clear and how the outcomes are measured and monitored is also clear.

Recommendation 4

The Trust must ensure that there is clarity about when clients should and should not be subject to Care Programme Approach and that individual operational policies do not contradict the Care Programme Approach policy.

Recommendation 5

The Trust must ensure that when a client is allocated to clinicians working in separate teams, a clear plan is in place to manage how communication will be managed between those clinicians and what action should be taken by whom if any issues need to be escalated.

Recommendation 6

The Trust must ensure that when a care coordinator is not at work for extended periods of time, appropriate plans are in place for the clients on his or her caseload to receive suitable support.

Recommendation 7

The Trust must ensure that the new guidance for documenting MAPPA discussions is included in the appropriate policy.

Recommendation 8

The Trust must implement a system to ensure that structured feedback is provided to all clinicians involved in the care and treatment of a client when there has been a serious incident investigation.

Recommendation 9

Commissioners must liaise with Sussex Police to agree a suitable approach for Trusts to fulfil their Duty of Candour responsibilities when there is an ongoing police investigation.

Recommendation 10

When managing the progress of action plans, Clinical Commissioning Groups must ensure that the effectiveness of new arrangements is monitored and that appropriate responses are in place to remedy non-compliance.

Suggestion for the Local Adult Safeguarding Board

8.15 We suggest that the Local Adult Safeguarding Board formally receives and considers this report in order to review any issues highlighted for non-NHS agencies. We would draw attention in particular to the issue raised in Recommendation 9.

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 K] received, which, had they been in place, could have predicted or prevented the incident. The investigation process should identify areas of best practice, opportunities for learning and areas where improvements to services are required which could prevent similar incidents from occurring.

2. The outcome of this investigation will be managed through corporate governance structures within NHS England, Clinical Commissioning Groups and the Provider.

Terms of Reference

3. Review the assessment and treatment that was provided by all NHS providers organisations (and including, where appropriate non NHS organisations) identified in the level 2 investigation, following an assessment by an Independent Consultant Psychiatrist in August 2012 up to the time of the incident on 8 September 2014.

4. Review the contact between the Police, Probation Service, the GP and Sussex Partnership NHS Foundation Trust services and assess if [Mr K's] risks to others were accurately and consistently understood and managed appropriately.

5. Review the effectiveness of communication, information sharing and decision making between agencies and services, including the Probation Service, MAPPA, GP and Sussex Partnership NHS Foundation Trust.

6. Review the documentation and record keeping of key information by the Sussex Partnership NHS Foundation Trust against its own policies, best practice and national standards

7. Review the Trust's internal investigation report and assess the adequacy of its findings, recommendations and implementation of the action plan and identify:

    - If the investigation satisfied its own terms of reference.
    - If all key issues and lessons have been identified and shared.
    - Whether recommendations are appropriate, comprehensive and flow from the lessons learnt
    - Review progress made against the action plan
    - Review processes in place to embed any lessons learnt

8. Having assessed the above, to consider if this incident was predictable, preventable or avoidable and comment on relevant issues that may warrant further investigation.

9. To review and comment on the Trust and CCGs enactment of the Duty of Candour.

10. To assess and review any contact made with the victim and perpetrator families involved in this incident, measured against best practice and national standards

11. To review and test the Trust and Clinical Commissioning Group's governance, assurance and oversight of serious incidents with particular reference to this incident.

Level of investigation

12. **Type B**: An investigation by a team examining a single case.

- Type A: a wide-ranging investigation by a panel examining a single case
- Type B: an investigation by a team examining a single case
- Type C: an investigation by a single investigator examining a single case (with peer reviewer)

13. **Timescale**: The investigation process starts when the investigator receives all the clinical records and the investigation should be completed within six months thereafter.

Initial steps and stages

NHS England will:

14. Ensure that the victim and perpetrator families are informed about the investigative process and understand how they can be involved including influencing the terms of reference

15. Arrange an initiation meeting between the Trust, commissioners, investigator and other agencies willing to participate in this investigation

16. Seek full disclosure of the perpetrator's clinical records to the investigation team

Outputs

17. We will require monthly updates and where required, these to be shared with families

18. A succinct, clear and relevant chronology of the events leading up to the incident which should help to identify any problems in the delivery of care

19. A clear and up to date description of the incident and any Court decision (e.g. sentence given or Mental Health Act disposals) so that the family and members of the public are aware of the outcome

20. A final report that can be published, that is easy to read and follow with a set of measurable and meaningful recommendations, having been legally and quality checked, proof read and shared and agreed with participating organisations and families (NHS England style guide to be followed)

21. Meetings with the victim and perpetrator families and the perpetrator to seek their involvement in influencing the terms of reference

22. At the end of the investigation, to share the report with the Trust and meet the victim and perpetrator families and the perpetrator to explain the findings of the investigation and engage the clinical commissioning group with these meetings where appropriate

23. A concise and easy to follow presentation for families

24. A final presentation of the investigation to NHS England, Clinical Commissioning Group, provider Board and to staff involved in the incident as required

25. We expect the investigators to include a lay person on their investigation panel to play a meaningful role and to bring an independent voice and challenge to the investigation and its processes.

26. We will require the investigator to undertake an assurance follow up and review, six months after the report has been published, to independently assure NHS England and the commissioners that the report's recommendations have been fully implemented. The investigator should produce a short report for NHS England, families and the commissioners and this may be made public

27. The investigator will deliver learning events/workshops for the Trust, staff and commissioners as appropriate.

Appendix B – Documents reviewed

Sussex Partnership NHS Foundation Trust documents

- Community Risk Assessment and Management Protocol & Guidance (V4) Secure & Forensic Services
- Clinical risk assessment and safety planning / risk management policy and procedure, ratification date unknown, provided as current risk policy
- Clinical Risk Assessment and Management Policy and Procedure, ratified January 2012
- Care Programme Approach Policy, ratified January 2016
- Care Programme Approach Policy, ratified October 2010
- Serious Incident (Si) Policy & Procedure ratified October 2012
- Incident & Serious Incident Reporting Policy & Procedure ratified October 2015
- Adult Risk Assessment Screening
- Forensic Community Outreach Service Operational Policy, ratification date unknown, provided as policy in place at the time and currently
- 2016-17 Q4 Trustwide Health Records Audit Report
- Community Risk Assessment and Management Guidance v3
- Referral Checklist
- Trustwide Health Records Audit 2015-16 v1.3
- Clinical records
- Serious Incident Investigation Report
- Action Plan
- Notes of interviews conducted by the internal investigation team

Other documents

- MAPPA Serious Case Review
- Probation Case Chronology
- Independent Report completed by Dr B, Independent Consultant Forensic Psychiatrist, August 2012

Appendix C – Professionals involved

Pseudonym	Role and organisation
Dr B	Independent Forensic Psychiatrist
Dr H2	Psychiatrist at HMP Cornwood
Dr M1	Clinical Psychologist, Hellingly Centre, Sussex Partnership NHS Foundation Trust
Dr M2	Forensic Psychologist, Hellingly Centre, Sussex Partnership NHS Foundation Trust
Dr R	Consultant Forensic Psychiatrist, Hellingly Centre, Sussex Partnership NHS Foundation Trust
Mr D	Offender Manager, HMP Maidstone
Mr E	Forensic Community Mental Health Nurse, Sussex Partnership NHS Foundation Trust
Mr J	Probation Officer, National Probation Service
Ms N	Case Manager, Parole Board