An independent investigation into the care and treatment of a mental health service user (Mr C) in Solent NHS Trust

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

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1 Executive summary

NHS England's Single Operating Model[1]

In June 2014 NHS England (South) commissioned Niche Patient Safety to conduct an independent investigation into the care and treatment of Mr C and to review the events that led up to the death of Mr D on 11 May 2013. In September 2014, due to legal issues, NHS England was advised that they needed to temporarily suspend the investigation. In March 2015 NHS England requested Niche Patient Safety to recommence their investigation. This case met the following criteria for the commissioning of an independent homicide investigation as set out in NHS England's Single Operating Model:[2]

"when a homicide has been committed by a person who is or has been in receipt of care and has been subject to the regular or enhanced Care Programme Approach of specialist health services in the six months prior to the event".[3]

The purpose of this investigation is to investigate the care and treatment of Mr C; to assess the quality of Solent NHS Trust's Serious Untoward Incident Report (SIR), which was commissioned following the incident; to review the implementation of the action plan that arose out of the findings of the SIR; and to identify whether any lessons can be learnt for the future which could prevent similar incidents from occurring. We have also been asked to consider whether the incident on 11 May 2013, which led to the death of Mr D, was either predictable[4] or preventable.[5]
This report was written with reference to the National Patient Safety Agency (NPSA) Root Cause Analysis Guidance. Root Cause Analysis (RCA) methodology has been utilised to both review and analyse the information obtained throughout the course of this investigation.

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[1] NHS England Delivering a Single Operating Model for Investigating Mental Health Homicides (2013)

[2] NHS England Delivering a Single Operating Model for Investigating Mental Health Homicides (2013), p7

[3] NHS England Delivering a Single Operating Model for Investigating Mental Health Homicides (2013), p7

[4] Predictability is "the quality of being regarded as likely to happen, as behaviour or an event". We will identify if there were any missed opportunities which, if actioned, may have resulted in a different outcome. An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it. *http://dictionary.reference.com/browse/predictability*

[5] Prevention means to "stop or hinder something from happening, especially by advance planning or action" and implies "anticipatory counteraction"; therefore, for a homicide to have been preventable there would have to have been the knowledge, legal means and opportunity to stop the incident from occurring. http://dictionary.reference.com/browse/predictability

Summary of events leading up to the incident from January 2013 to 11 May 2013

At the time of the incident (11 May 2013), Mr C was 40 years old and had a diagnosis of treatment-resistant paranoid schizophrenia with co-morbid[6] substance misuse. Historically Mr C had also been given several other mental health diagnoses, including bipolar disorder, depression and a personality disorder.

In July 2012 Mr C relocated to the Solent area. During the transition the Southern Health Assertive Outreach Team (AOT) supported him until January 2013, at which point his mental health care was transferred to Solent NHS Trust. On 29 January 2013 Mr C presented in a psychotic state in a public place it was thought [7] that he had taken MDMA.[8] He was admitted as an informal patient to the local acute mental health inpatient unit for a 20-day admission. He was discharged back to Solent's AOT (19 February). Mr C was readmitted two days later, having taken an overdose of prescribed medication. This admission was for 11 days and he was again discharged (5 March) into the care of the AOT. The AOT documented that they were experiencing difficulty engaging Mr C and that his parents were voicing their concerns about their son's increasingly chaotic behaviour. Mr C's last hospital admission was on 4 April 2013 when he was detained under a section 2 of the Mental Health Act (1983).[9] During this 21-day admission Mr C's behaviour was documented as being erratic and there were five reported episodes of violence towards other patients. After Mr C's discharge he was seen by his care coordinator from the AOT on two occasions, on both occasions it was assessed that he was stable and compliant with his medication.

The pharmacist who was dispensing medication to Mr C on a daily basis reported that on the day before the incident Mr C had collected his medication and that he had no concerns regarding Mr C's presentation. Mr C's parents also reported to us that they had seen their son the day before the incident and that they also had no particular concerns about him. With regard to Mr C's relationship with the victim, Mr D; it was documented[10] that in April 2013 Mr C had met Mr D through a mutual friend and that they had socialised together in the week prior to the incident. Mr D's parents reported to us that before the incident they and members of their extended family had been in regular contact with their son.

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[6] The term "co-morbidity" describes two or more disorders or illnesses occurring in the same person

[7] Solent NHS Trust Serious Incident Report, p4

[8] MDMA (3,4-methylenedioxy-methamphetamine),popularly known as ecstasy

[9] Under a section 2 a patient is detained in hospital for assessment of their mental health and to receive treatment. This section is for up to 28 days

[10] Appeal hearing 2015

At 5:55pm on 11 May 2013 Mr C telephoned the police to report the incident. The police officer who was the first present at the scene reported that Mr C "repeatedly maintained that the deceased had attacked him with the knife, which he took and used to defend himself."[11] Mr C has consistently maintained that he acted in self-defence. The pathologist reported that Mr D sustained 38 stab wounds which were caused by a butterfly knife that was owned by Mr C. Analysis of blood samples taken from Mr C, at both 12 and 25 hours after the incident, "revealed an absence or low concentration of alcohol."[12]

At a subsequent Crown court hearing (12 March 2014), Mr C was found unfit to plead and was subsequently detained on under section 37/41 (Mental Health Act 1983) hospital order (21 March 2014).[13] He is currently a patient in a medium secure psychiatric hospital.

Summary of background information

Mr C first began to exhibit mental health symptoms at the age of 17 when he was an army cadet and undertaking basic training. This appeared to have coincided with reports that he had begun to use illegal drugs. On 29 July 1993 Mr C was first admitted, initially on an informal basis, to a psychiatric inpatient unit. He reported that he had been experiencing increasingly intrusive thoughts. During this admission Mr C was involved in two serious incidents which involved knives.[14] A forensic risk assessment that was completed at the time reported that Mr C had become "more disturbed and more dangerous."[15]

From 1996 Mr C's polysubstance misuse and in later years his use of legal highs, as well as his misuse of his prescribed medications, especially benzodiazepine,[16] were repeatedly being identified as a significant antecedent[17] and a contributory factor in the deterioration in his mental health. From 1994 to 2005 Mr C was being regularly admitted to psychiatric inpatient units either as a voluntary patient or under section 2 or 3 of the Mental Health Act (1983). During these admissions it was assessed that

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11 Reported in Mr C's appeal hearing 2015

12 Reported in Mr C's appeal hearing 2015

13 The criminal courts can use a section 37 if they think a patient should be in hospital instead of prison. Section 41 is a restriction order. The Crown court can add this order to a section 37 if they have concerns about public safety and a patient's level of risk

14 Letter from consultant forensic psychiatrist to locum consultant psychiatrist, 19 August 1993

15 Letter from consultant forensic psychiatrist to locum consultant psychiatrist, 13 August 1993

16 Benzodiazepines are a class of psychoactive drugs used to treat anxiety, insomnia and a range of other conditions

17 An antecedent is a thing that comes before something else

Mr C posed an ongoing threat to both himself and others. In January 2005 Mr C was transferred to a medium secure unit.

During the five years when Mr C was an inpatient at the medium secure unit there continued to be numerous occasions when he physically assaulted and made verbal threats towards both staff and other patients. In November 2005 it was assessed that he had a "continued risk of violence combined with on-going illicit substance misuse, non-compliance with treatment and what appears to be treatment resistant schizophrenic illness."[18] Therefore, Mr C's continued detention in a medium secure unit was considered necessary for the "health and safety"[19] of himself but also for the "protection of other persons."[20]

Mr C remained in the unit until 22 November 2010, at which point he moved into a supported housing scheme where he continued to be supported by Southern Health's AOT and a community outpatient consultant psychiatrist, and he was also receiving intensive support from a key worker at the housing scheme. However, this placement rapidly broke down in March 2011 due to Mr C's increasingly aggressive and intimidating behaviour towards staff, other residents and neighbours. He was then admitted to a Psychiatric Intensive Care Unit (PICU), under a section 2[21] and subsequently a section 3[22] of the Mental Health Act (1983).

Mr C's parents reported to us that due to the considerable delay on the part of statutory services in finding their son suitable accommodation, they eventually secured him private rented accommodation. However, they became increasingly concerned about their son's association with the local drug fraternity, which resulted in his tenancy being at significant risk. Therefore, they secured a private rented flat for him in the Solent locality. Mr C moved in July 2012, and in order to provide continuity of care during this transitional period, Southern Health's AOT supported Mr C until January 2013. During this period there were three hospital admissions following incidents of self-harm and overdosing. During one of these admissions it was assessed that Mr C's risks towards both himself and others were heightened by his continued "use of alcohol and illicit substances and his frustrations at not having his needs met."[23]

On 17 January Mr C was arrested for possession of an offensive weapon (knife) in a public place and for allegedly stalking a female shop worker. The CPS later decided that Mr C would only face a charge of possession of an offensive weapon. Mr C was last seen by the Community Justice Team (CJT) on 6 May 2013, when he and his

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18 Mental Health Review Tribunal Report, 1 July 2007

19 Mental Health Review Tribunal Report, 1 July 2007

20 Mental Health Review Tribunal Report, 1 July 2007

21 Section 2 of the Mental Health Act (1983) detained for up to 28 days for assessment

22 Section 3 of the Mental Health Act (1983) detained for up to six months

23 Risk assessment, 30 October 2012, p3

father attended a court hearing in relation to this charge. The case was pending at the time of the incident.

Summary of findings

During the course of our investigation we identified the following significant issues:

The management of the transfer of Mr C's care from Southern Health NHS Foundation Trust's mental health services to Solent's AOT and inpatient services: it was reported to us[24] that despite the extensive involvement of Southern Health's AOT, the actual transfer occurred when his coordinator was on holiday. We were unable to ascertain why the transfer occurred at this time and it was reported to us by Solent AOT that in their opinion the transfer was "fairly abrupt."[25] As there had not been the opportunity to convene a care planning meeting there had been a number of significant unresolved issues; for example, Mr C had not been reviewed by the community psychiatrist from Solent and arrangements for the collection of medication from a pharmacy had yet to be resolved.

The transfer of notes from Southern Health NHS Foundation Trust to Solent NHS Trust: without exception all practitioners from Solent's mental health services (AOT and the inpatient unit) repeatedly identified to us that this was an ongoing issue i.e. the lack of sufficient information being transferred when a patient moves from Southern Health to Solent's services. Several Solent clinicians also reported to us that they had known Mr C from previous episodes of care[26] and that due to the lack of information that was available to either Solent's AOT or the inpatient unit[27] they had relied on information supplied by either Mr C, who was often an unreliable self-historian, or from members of staff who had historical knowledge of him to inform both their assessments and clinical judgements. We could find no evidence of any proactive efforts made by anyone from Solent's services to obtain Mr C's full psychiatric history. We were informed that as part of the lessons learnt from this incident Solent NHS Trust have developed and implemented a Protocol for Receiving and Referring Transfers of Care between Solent NHS Trust and External NHS Organisations.

Solent NHS Trust's risk assessments: we noted that the risk assessment form being used at the time did not assess levels of risk, but merely documented issues in either "the last six months or ever." We also noted that the narrative sections within Mr C's risk assessment did not always correlate with the risks that had been identified within the risk grid.

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24 By care coordinators from both Southern Health and Solent and also a AOT manager

25 Interview with Solent care coordinator

26 By care coordinator and inpatient consultant psychiatrist

27 30 January to 19 February 2013, 22 February to 5 March 2013 and 4 April to 25 April 2013

It was explained to us that the rationale behind the decision to discharge Mr C from his Solent inpatient admissions was that he was considered a "challenging patient but not high risk."[28] Although, given his history of violence and carrying weapons his long-term risks would always remain "significant" [29](i.e. medium to high) however when he was stabilised on medication and was not using illegal drugs or legal highs his acute psychotic symptoms reduced. At such times his immediate risks would then be considered as low. At this point he would be assessed as being fit for discharge.

Care planning: the care plan pro forma that was utilised at the time did not indicate if a patient had agreed to the documented goals, nor if they were asked to sign or if they had been offered a copy of the care plan. It was reported to us that the main focus of the hospital admissions was to stabilise Mr C on various medication regimes and to manage his behaviour on the ward. With regard to psychological and therapeutic support, it was reported to us that it was felt that Mr C's continued unsettled and chaotic behaviour, which was being exacerbated by his ongoing polysubstance misuse, made him an unsuitable candidate for more therapeutic interventions. When Mr C was given the opportunity to engage with specialised drug and alcohol services, such attempts failed due to his ongoing ambivalence and at times lack of insight into the detrimental effects of his continued polysubstance misuse.

It was also identified within Mr C's care plan when he moved to Solent that he was lacking the more practical skills required for independent living, for example cooking and shopping, and that he was experiencing considerable social isolation. There appeared to have been no consideration given to the possibility of applying for Personalised or Direct Payment Budgets[30] for Mr C. We would suggest that a Personalisation Budget could have funded additional support hours for Mr C; such support would have enabled the provision of a more extensive programme of rehabilitation that statutory services were unable to offer. It would also have provided additional monitoring of Mr C's mental health and his ongoing vulnerabilities.

Carers' assessment: it was clearly evident that from 1999, when Mr C first came to the attention of mental health services, both Mr C's parents and also other members of his family were very actively involved in supporting Mr C both when he was living in the community and also during his numerous hospital admissions. Mr C's parents reported to us that they had felt that they had been regularly consulted and included in the care of their son when he was a patient of Southern Health mental health services and also when he was at the medium secure unit. However, they reported that they had not been consulted or included in their son's care and discharge planning during his Solent hospital admissions. Although there were several occasions where it was documented that the care coordinator spoke to Mr C's father regarding his son being referred to more suitable accommodation, Mr C's parents

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28 Interview with inpatient consultant psychiatrist

29 Interview with inpatient consultant psychiatrist

30 Personal and Direct Payments Budgets: allocation of funding given to users after a social services assessment of needs

reported to us that they had never been offered a carers' assessment by either Southern Health or Solent services. This was confirmed in our review of the extensive documentation available to us from both areas.

Housing: it was clearly evident to us that the ongoing lack of appropriate and secure accommodation was an issue throughout Mr C's adult life. On two occasions Mr C's hospital discharge was significantly delayed due to a lack of suitable accommodation being available. We also noted that on two occasions he had been issued with eviction notices due to his inappropriate behaviour and associations with other drug users in the area.

Information sharing with primary care services: we saw evident that following both Mr C's CPA reviews and discharges from the inpatient unit his GP was sent updated care plans which included some risk information. The GP who we interviewed agreed that it would be helpful for the more complex patients, such as Mr C who are on an Enhanced CPA, that following a CPA review where significant changes in the patient's risk factors or medication have been identified the care coordinator should discuss with the GP, ideally in person at the surgery but if this is not feasible then by telephone, in order to discuss the future management of the patient.

Post-incident Serious Incident Review (SIR)

As part of NHS England's Terms of Reference (TOR) for this investigation we were asked to "review the trust's internal investigation and assess the adequacy of its findings, recommendations and action plan."[31] We concluded that the SIR provided a comprehensive chronology of and commentary on events from the point Mr C was transferred to Solent's community and inpatient services to the incident itself.

We did however identify the following issues that we would like to draw the Trust's attention to in order to improve future SI investigations:

The author of the SIR interviewed Mr C's parents and the SIR documents their experiences, concerns and what they perceived as a lack of involvement in their son care whilst he was receiving care from Solent NHS Trust's mental health services. However, the SIR failed to identify that they had not been offered a carers' assessment. This, we would suggest, should have been identified as a significant failure on the part of all services.

Mr C's parents reported to us that although they had appreciated being involved in the SIR process but they could not recall receiving any feedback from the findings of the SIR report. We were informed by Solent NHS Trust that they did meet Mr C's parents where they gave them a copy of the SIR report and also discussed its findings.

It was also not clear to us if the SIR utilised a clearly identifiable underpinning methodology. We would suggest that utilising a clearly established methodology,

[31] TOR Appendix B

such as Root Cause Methodology, would have assisted both the author and the reader to distinguish between the root causes and many contributory factors.

We also noted that the SIR did not include an Executive Summary as prescribed within the National Patient Safety Agency's RCA Investigation Evaluation Checklist. For future reference, we would recommend that all SIRs contain an Executive Summary that includes the following: care and delivery issues, root causes, contributory factors and lessons learnt.

Solent NHS Trust's progress on implementing the recommendations from the Serious Incident Review

Based on the SIR's recommendations Solent NHS Trust developed a comprehensive action plan which identified both a start and an end date, individuals who were responsible for each action and the associated outcomes and targets for the completion of each target.

In our discussions with various practitioners and the Trust's managers it was very evident that since this incident, both inpatient and community services have undergone a significant period of rapid and extensive changes. New care pathways, reporting and levels of accountability, as well as a universal recovery focus, now underpin all care plans and service delivery. We were informed that the aim of all the changes being implemented was to minimise hospital admissions, to provide consistency and continuity of care, to monitor compliance and to improve the standards of record keeping.

Both the Trust and local primary care services are in the process of developing and implementing a bespoke patient records system (SystmOne). This, it is hoped, will allow for greater access to information across services. It was evident to us that this has been a challenging time for Solent's practitioners and senior managers and as one senior Trust manager reported to us, it is still a "work in progress."[32]

Predictability and preventability

Throughout the course of this investigation we have remained mindful that one of the requirements of NHS England's Terms of Reference is that we need to consider if the incident which resulted in the death of Mr D was either predictable or preventable. Whilst analysing the evidence we obtained we have borne in mind the following definition of a homicide that is judged to have been predictable, which is one where "the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it."[33]

Clearly a significant amount of information regarding Mr C's mental health history has only come to light during the course of this investigative process, as we were able to access the extensive clinical and social care notes from Mr C's admission to

[32] Interview with Quality and Standards Lead

[33] 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

the medium secure unit, his primary care notes and details from the police of their involvement with Mr C dating back to the 1990s. This information was unavailable to both the author of the SIR and clinicians from Solent's services. This benefit of hindsight[34] has been extremely useful to us, as it has enabled us to develop a more comprehensive profile of Mr C's extensive mental health history, his continual risk of violence towards others and his own ongoing vulnerability to exploitation, as well as the repeated issues and concerns that were being reported by Mr C's parents regarding their son's wellbeing.

Predictability: during the course of our investigation we encountered repeated narratives, dating back to the 1990s, that indicated that Mr C had a long and extensive history of carrying weapons, knives in particular, and that he had been involved in repeated incidents of both verbal and physical aggression, violence and frequent disinhibited behaviours towards others, especially during periods when he was acutely psychotic. From 2002 it was being assessed[35] that Mr C "had almost a reckless disregard for the safety of others, [and] a lack of empathy which rendered him a danger to himself as well as others."[36] It was also extensively documented that Mr C repeatedly exhibited low tolerance to frustrations and that he persistently minimised the severity and effects of the incidents of violence and aggression, always citing provocation from others to explain his actions. Mr C would frequently use threats of violence towards others and self-harm as a coping strategy. As far back as 2001 it was documented that Mr C was consistently assessed as having a combination of extremely high risk factors of violence and very few protective factors.

Throughout Mr C's extensive documented mental health history and in the events that led up to the incident it was well documented that Mr C persistently showed resistance to any therapeutic interventions and had a poor response to the many different psychiatric medications that he was prescribed.

We concluded that even based on the partial information that was known at the time of the incident it was highly predictable that Mr C would be involved in another impulsive violent incident. Such an incident would either involve someone who was known to him or a stranger, as both had previously been victims of violent assaults by Mr C.

Preventability: In our consideration of the preventability of the incident, which resulted in the death of Mr D, we have asked ourselves the following questions. Was

[34] Hindsight bias is when actions that should have been taken in the time leading up to an incident seem obvious because all the facts become clear after the event. This leads to judgment and assumptions around the staff closest to the incident. Outcome bias is when the outcome of the incident influences the way it is analysed. For example, when an incident leads to a death, it is considered very differently from an incident that leads to no harm, even when the type of incident is exactly the same. When people are judged one way when the outcome is poor and another way when the outcome is good, accountability may become inconsistent and unfair. (NPSA 2008)

[35] Report to the Mental Health Review Tribunal, 8 July 2008

[36] Report to the Mental Health Review Tribunal, 8 July 2008, p1

it reasonable to have expected agencies and individual clinicians to have taken more proactive steps, when he was transferred to Solent services, to obtain a comprehensive historical profile of Mr C? Also, if a more comprehensive profile had been obtained would it have significantly changed the various risk assessments and services that Mr C was provided with? Additionally, based on the information that was known at the time of the incident, was the decision to discharge Mr C following his final inpatient admission (April 2013) clinically safe and was the level of community support that was available to him adequate to manage his known risk factors? We have asked ourselves did any one factor or a possible combination of all result in a failure to either adequately identify or assess Mr C's potential risks of violence towards others. Additionally if alternative actions had been taken would they have prevent this incident itself from occurring?

We have identified several missed opportunities that would have enabled the identification that it was highly predictable that Mr C would be involved in another impulsive violent incident. At the time of the incident it had been assessed that although there were known risk factors Mr C was clinically fit for discharge from his last inpatient admission and that he had the capacity to make the decision to live independently. Clearly based on Mr C's previous history this decision had significant ongoing risk factors that could be mitigated to a limited extend by the support offered by AOT. This meant that apart from occasional visits by the AOT Mr C was mostly living unsupervised in the community. All that AOT practitioners were able to do was to schedule regular visits in order to support Mr C, to monitor both the known risks and signs of deterioration and to liaise with the pharmacist, who was monitoring Mr C collection of medication and presentation. The care coordinator was therefore reliant on Mr C attending these meetings, his self-reporting and taking proactive measures when concerns were being expressed by Mr C's parent. However for the majority of the time Mr C was left to his own resources, which were clearly limited, and he remained vulnerable to both exploitation from others and to his high-risk lifestyle.

We concluded that it was extremely unfortunate that the forensic assessment was not undertaken during Mr C's last inpatient admission (April 2013). As this would have been the opportunity to obtain and review Mr C's forensic records from the medium secure unit thus enabling a more comprehensive assessment of Mr C's risk factors and a risk management plan to be developed by both Solent's inpatient unit and AOT service. For example the last risk assessment and management plan that was undertaken prior to Mr C being discharged from the medium secure unit (November 2010) noted that if he disengaged with mental health services, stopped taking his medication and returned to illegal drug use he should be admitted directly to a PICU, and that if he required longer-term treatment he should be transferred back to a medium secure unit. As this advice was not available it was not considered as a possible option.

We therefore concluded that in our opinion even if more informed risk assessments information had been available, given the fact that Mr C was living alone in the community, with no restrictions, e.g. a Community Treatment Order, and limited supervision it is unlikely that the events of 11 May 2013 could have been prevented. However we do suggest that if Mr C had been resident in a more supervised environment, such as an intensive supported housing scheme, he would have been more closely supervised. In such a setting there might have been a greater

opportunity for monitoring Mr C's mental health and polysubstance misuse and for identifying any escalating risks. His daily activities would have also been more closely monitored and there would have been greater regulations imposed with regards to visitors and alcohol consumption on the premises.

Concluding comments

It was clearly evident that Mr C suffered from a significant and treatment resistant major mental health illness combined with antisocial personality traits, continued polysubstance misuse and was regularly non-compliance with his medication regime. All of which resulted in him having extremely high ongoing risk factors and complex needs. Mr C also had an extensive history of violence towards others and whilst he was in the community he was also vulnerable to exploitation from others. From the point Mr C was transferred to Solent services it was evident that due to Mr C's repeated mental health crises, they were having to provide a reactive service with little opportunity to develop comprehensive risk assessments or support plans.

We also concluded that the repeated historic failure to secure Mr C suitable supported accommodation was a significant issue, as it not only contributed to his ongoing vulnerabilities but also meant that Mr C was not being as closely monitored and supported as he, in our opinion, clearly needed to be.

Finally, we would like to suggest that although the TOR asked us to look at the care provided by Solent NHS Foundation Trust we have also identified some concerns and issues that are of relevance to Southern Health NHS Foundation Trust's mental health services. Especially with regard to the transfer of care of their complex and vulnerable patients to other Trusts. It is therefore our hope that our report and findings will also be shared with Southern Health NHS Foundation Trust.

Recommendations

Recommendation 1: For patients on Enhanced CPA when there has been a significant change in either their risk factors or medication, which have been made at their CPA review or during an inpatient admission, their care coordinator should discuss with the GP the future management of the patient.

Recommendation 2: Where there is a planned transfer of a patient between NHS Trusts the responsible clinician must ensure, wherever possible, that the transfer of medical records is completed before they accept responsibility for the patient's care.

Recommendation 3: A full review of a patient's historical medical notes must be undertaken by both inpatient and community services as part of their initial clinical and risk assessment.

Recommendation 4: Solent NHS's Trust's revised risk assessment form should have separate sections for historical, current and ongoing risk factors. Each risk factor identified should be cross-referenced in the narrative section. Triggers and protective and contributory factors should be clearly identified for every area of risk.

Recommendation 5: Risk information should only be documented in one location within Solent NHS Trust's patient records system.

Recommendation 6: Consideration should be given during discharge and CPA planning to apply for Personalised Budgets or Direct Payments to fund additional care and support needs.

Recommendation 7: Risk assessments and support plans should always be identifying and considering a patient's housing situation. Where a patient is experiencing housing issues, this should be identified and considered as a significant risk factor and one that requires multi-agency intervention.

Recommendation 8: Serious Incident Review authors should always utilise and demonstrate within their report the underpinning investigative methodology that they are using, e.g. a Fishbone analysis of contributory factors.

Recommendation 9: Serious Incident Review reports must fully comply with guidelines outlined in the National Patient Safety Agency's RCA Investigation Evaluation Checklist.

Recommendation 10: In order to evaluate the effectiveness of Solent NHS Trust's Protocol for Receiving and Referring Transfers of Care an audit should be undertaken of a number of individual cases where this protocol has been utilised.

Recommendation 11: NHS England should consider providing a copy of this report to Southern Health NHS Foundation Trust.

Niche Patient Safety's condolences to the family of the victim:

Niche's investigation team would like to offer their deepest sympathies to the family of the victim. It is our sincere wish that this report does not contribute further to their pain and distress.

Niche's investigation team would also like to thank the families of both Mr C and Mr D for their invaluable contribution to this investigation.

Acknowledgement of participants:

Niche's investigation team would like to acknowledge the contribution and support that the staff from Solent NHS Trust and Southern NHS Foundation Trust and Hampshire Constabulary have provided throughout the course of the investigation.

2 Offence

2.1 At the time of the incident (11 May 2013) Mr C was 40 years old and had been known to mental health services since 1991. He had a diagnosis of treatment-resistant paranoid schizophrenia with co-morbid[37] substance misuse. Historically he had also been given several other mental health diagnoses, including bipolar disorder, depression and a personality disorder.

2.2 Mr C's last psychiatric inpatient admission was on 4 April 2013 when he was detained under a section 2 of the Mental Health Act (1983).[38] During this 21-day admission Mr C's behaviour was documented as being erratic. There were five reported episodes of violence towards other patients and staff and one occasion when he absconded from the unit.

2.3 On 25 April Mr C was discharged back to the care of Solent NHS Trust's Assertive Outreach Team (AOT). Mr C was seen by his care coordinator from the AOT six days post discharge (1 May) and then again on 3 May. On both occasions it was assessed that he was stable and compliant with his medication.

2.4 Mr C was also seen by the Criminal Justice Team (CJT) on 6 May when he was accompanied by his father to a court hearing in relation to a charge of possession of an offensive weapon. The case was due to be heard at Crown court on 31 May 2013.

2.5 The pharmacist who was dispensing medication to Mr C, on a daily basis, reported on the day before the incident that Mr C had collected his medication and that he had no concerns regarding Mr C's presentation. Mr C's parents also reported to us that they had seen their son the day before the incident and that they had no particular concerns about him.

2.6 With regard to Mr C's relationship with the victim, Mr D; it was documented[39] that in April 2013 Mr C had met Mr D through a mutual friend and that in the weeks prior to the event they had been socialising.

2.7 Mr D's parents reported to us that before the incident they and members of the extended family had been in regular contact with their son. They also reported that they had no concerns about Mr D's welfare and they had not been aware of his friendship with Mr C.

2.8 At 5:55pm on 11 May 2013 Mr C telephoned the police, reporting that "I've a dead person in my front room … he's took about twenty or thirty stabs … to his neck chest and back." In response to further questions Mr C reported: "'He

[37] The term "co-morbidity" describes two or more disorders or illnesses occurring in the same person

[38] Under a section 2 MHA, a patient is detained in hospital for assessment of their mental health and to receive treatment. This section is for up to 28 days

[39] Appeal hearing 2015

started on me with a weapon. I took the weapon off him and defended myself … he kept coming back and back with the weapon. He said that the knife belonged to him." When police officers arrived they found Mr C with blood on his clothing and a cut to his wrist.[40] The pathologist reported that Mr D had sustained 38 stab wounds, which were caused by a butterfly knife that was owned by Mr C.

2.9 The first attending police officer reported that Mr C "repeatedly maintained that the deceased had attacked him with the knife, which he took and used to defend himself. He identified the knife that he had taken from the deceased."[41] Mr C has also consistently maintained that he acted in self-defence.

2.10 Mr C sustained the following injuries: a cut to the bridge of his nose; a one-inch laceration on his right wrist, for which he required hospital treatment; a cut to his small finger on his left hand.

2.11 Analysis of blood samples taken from Mr C at both 12 and 25 hours after the incident "revealed an absence or low concentration of alcohol"[42] in his blood. Mr C reported[43] that on the day of the incident he had drunk three measures of a liqueur.

2.12 At a subsequent Crown court hearing (12 March 2014) Mr C was found unfit to plea and he was subsequently detained under a section 37/41 (Mental Health Act 1983) hospital order (21 March 2014).[44] He is currently a patient in a medium secure psychiatric hospital.

3 Independent investigation

3.1 From 2013 NHS England assumed overarching responsibility for the commissioning of independent investigations into mental health homicides and serious incidents. On 1 April 2015 NHS England introduced its revised Serious Incident Framework,[45] which "aims to facilitate learning by promoting a fair, open, and just culture that abandons blame as a tool and promotes the belief that incidents cannot simply be linked to the actions of the individual healthcare staff involved but rather the system in which the individuals were

[40] Reported in Mr C's appeal hearing 2015

[41] Reported in Mr C's appeal hearing 2015

[42] Reported in Mr C's appeal hearing 2015

[43] Reported in Mr C's appeal hearing 2015

[44] The criminal courts can use a section 37 if they think a patient should be in hospital instead of prison. Section 41 is a restriction order. The Crown court can add this order to a section 37 if they have concerns about public safety and a patient's level of risk

[45] NHS England, Serious Incident Framework. Supporting learning to prevent recurrence, 1 April 2015

working. Looking at what was wrong in the system helps organisations to learn lessons that can prevent the incident recurring."[46]

3.2 Identified within this Serious Incident Framework are the following criteria for the commissioning of an independent investigation:

> "When a homicide has been committed by a person who is or has been in receipt of care and has been subject to the regular or enhanced care programme approach, or is under the care of specialist mental health services, in the 6 months prior to the event."[47]

3.3 The Framework also cites that a standardised approach to investigating such incidents is to:

> "Ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence.
> Facilitate further examination of the care and treatment of the patient in the wider context and establish whether or not an incident could have been predicted or prevented, and if any lessons can be learned for the future to reduce the chance of recurrence.
> Ensure that any resultant recommendations are implemented through effective action planning and monitoring by providers and commissioners."[48]

3.4 In June 2014 NHS England commissioned Niche Patient Safety to undertake an independent investigation into the homicide of Mr D.

3.5 In September 2014, due to legal issues, NHS England was advised that they needed to temporarily suspend the investigation. In March 2015 NHS England requested Niche Patient Safety to recommence their investigation.

Purpose and scope of the investigation

3.6 The purpose of this investigation is to investigate the care and treatment of Mr C; to assess the quality of Solent NHS Trust's Serious Incident Report (SIR), which was undertaken following the incident; to review the implementation of the Solent NHS Trust's action plan that arose out of the findings of the SIR; and to identify whether any lessons can be learnt for the future which could prevent similar incidents from occurring. We have also been asked to

[46] NHS England, Serious Incident Framework. Supporting learning to prevent recurrence, p10

[47] NHS England, Serious Incident Framework. Supporting learning to prevent recurrence, p47

[48] NHS England, Serious Incident Framework. Supporting learning to prevent recurrence, p48

consider whether the incident on 11 May 2013, which led to the death of Mr D, was either predictable[49] or preventable.[50]

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

3.8 The full Terms of Reference that were agreed with NHS England are located in Appendix B.

Approach to the investigation

3.9 The investigation was carried out by Niche's Senior Investigator Grania Jenkins, with expert advice provided by Dr Ian Cumming and Daniel Barrett was the lay peer reviewer.

3.10 The report has been peer-reviewed by Carol Rooney, Niche's Senior Investigations Manager and Nick Moor, Niche's Director.

3.11 Niche Patient Safety is a leading national patient safety and clinical risk management consultancy which has extensive experience in undertaking complex investigations following serious incidents and unexpected deaths. Niche also undertakes reviews of governance arrangements and supports organisational compliance with their regulatory frameworks across a range of health and social care providers.

3.12 For the purpose of this report, the investigation team will be referred to in the first person plural and Niche Patient Safety will be referred to as Niche.

3.13 This report was written with reference to the National Patient Safety Agency's (NPSA) Root Cause Analysis Guidance.[51]

3.14 Root Cause Analysis (RCA) methodology has been utilised to review the information obtained throughout the course of this investigation.

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[49] Predictability is "the quality of being regarded as likely to happen, as behaviour or an event". We will identify if there were any missed opportunities which, if actioned, may have resulted in a different outcome. An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it. http://dictionary.reference.com/browse/predictability

[50] Prevention means to "stop or hinder something from happening, especially by advance planning or action" and implies "anticipatory counteraction"; therefore, for a homicide to have been preventable there would have to have been the knowledge, legal means and opportunity to stop the incident from occurring. http://dictionary.reference.com/browse/predictability

[51] National Patient Safety Agency (NPSA) Root Cause Analysis Guidance

3.15 RCA is a retrospective multidisciplinary approach designed to identify the sequence of events that led to an incident. It is an iterative[52] structured process that has the ultimate goal of preventing future adverse events by the elimination of latent errors.

3.16 RCA also provides a systematic process for conducting an investigation, looking beyond the individuals involved and seeking to identify and understand the underlying system features and the environmental context in which an incident occurred. It also assists in the identification of common risks and opportunities to improve patient safety and informs recommendations regarding organisational and system learning.

3.17 The prescribed RCA process includes data collection and a reconstruction of the event in question through record reviews and participant interviews.

3.18 As part of the investigation process we have utilised an RCA Fishbone diagram to assist the investigative team in identifying the influencing and multiple contributory factors which led to the incident (Fishbone is located in Appendix A).

3.19 Where appropriate we have referred to relevant national and local policies and guidelines, to the Department of Health's (DH) best practice[53] guidelines and to the relevant NICE[54] guidance.

3.20 As far as possible we have tried to eliminate or minimise hindsight or outcome bias[55] in our investigation. We analysed information that was available to primary and secondary care services at the time. However, where hindsight informed our judgements, we have identified this.

3.21 As part of this investigation we interviewed the following: GP (Solent), Police Family Liaison Officer, consultant psychiatrists (from both the acute inpatient unit and the medium secure unit), Chief Nurse (Solent), Speciality Doctor (acute inpatient unit), care coordinators (from Southern Health and Solent NHS Trusts' AOTs), Manager of Intensive Engagement Team (Solent),

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[52] Iteration is the act of repeating a process with the aim of approaching a desired goal, target or result

[53] DH (March 2008), Refocusing the Care Programme Approach Policy and Positive Practice and Code of Practice Mental Health Act 1983 (revised)

[54] NICE: National Institute for Health and Care Excellence

[55] Hindsight bias is when actions that should have been taken in the time leading up to an incident seem obvious because all the facts become clear after the event. This leads to judgment and assumptions around the staff closest to the incident. Outcome bias is when the outcome of the incident influences the way it is analysed. For example, when an incident leads to a death, it is considered very differently from an incident that leads to no harm, even when the type of incident is exactly the same. When people are judged one way when the outcome is poor and another way when the outcome is good, accountability may become inconsistent and unfair. (NPSA 2008)

Quality and Standards Lead for Adult Mental Health Services (Solent), Modern Matron (acute inpatient unit Solent), Frontline Advisor Outreach Service (Solent) and Team Manager from the Criminal Justice Team (CJT). We also carried out a telephone interview with the author of the SIR.

3.22 Interviews were managed with reference to the National Patient Safety Agency's (NPSA) investigation interview guidance.[56] We also adhered to the Salmon/Scott principles.[57]

3.23 We had access to both the police's report that was compiled for Mr C's original trial, as well as the findings from the subsequent appeal hearing.

Anonymity

For the purpose of this report:

3.24 The identities of all those who were interviewed have been anonymised and they will be identified by their professional titles.

3.25 Services have been anonymised and are referred to by their service type only.

3.26 The patient is referred to as Mr C and the victim as Mr D.

Involvement of Mr C, members of his family and members of the victim's family

3.27 NHS's Serious Incident Framework directs that all investigations should:

> "Ensure that families (to include friends, next of kin and extended families) of both the deceased and the perpetrator are fully involved. Families should be at the centre of the process and have appropriate input into investigations."[58]

3.28 As part of all Niche's investigations we will always try to obtain the views of the patient and the families of both the victim and the perpetrator, not only in relation to the incident itself but also their wider thoughts regarding where improvements to services could be made in order to prevent similar incidents from occurring again.

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[56] National Patient Safety Agency (2008) Root Cause Analysis Investigation Tools: investigation interview guidance

[57] The 'Salmon process' is used by a public inquiry to notify individual witnesses of potential criticisms that have been made of them in relation to their involvement in the issue under consideration. The name derives from Lord Justice Salmon, Chairman of the 1996 Royal Commission on Tribunals of Inquiry, whose report, amongst other things, set out principles of fairness to which public inquiries should seek to adhere

[58] NHS England, Serious Incident Framework. Supporting learning to prevent recurrence, p48

3.29 We met with Mr C on 24 March 2015.

3.30 On 26 March 2015 we met with the parents of both Mr C and Mr D and we have also had ongoing contact with them throughout the course of this investigation process. The information they have provided has been essential in assisting us to identify the chronology of events that led up to the incident itself. We have greatly appreciated their continued support in this investigation; they have selflessly provided valuable background information into the lives of both Mr C and Mr D.

3.31 We will offer Mr C, his family and Mr D's family the opportunity to be provided with a copy of our report and if they wish we will also meet with them to provide verbal feedback on our findings and recommendations.

Structure of the report

3.32 This report has been divided into various sections and subsections. Where relevant each section has a commentary on and an analysis of the information we have obtained.

3.33 As Mr C had an extensive and complex mental health history we have divided the section on his psychiatric history into several chronological stages. There is also a separate section that looks at Mr C's ongoing housing issues.

3.34 At the end of each section there are the associated recommendations. There is also a list of all the recommendations in section 14.

3.35 We have provided a full chronology from the point Mr C was transferred from Southern Health NHS Foundation Trust to Solent's services. This is located in Appendix B.

4 The care and treatment of Mr C

Childhood and family background

4.1 Mr C had two biological sisters and two half siblings. Mr C's mother was of Germanic origin and his father was a member of the armed forces. At the time of the incident both parents had retired and were living in the UK.

4.2 It is documented that Mr C reached all his early developmental milestones. His parents reported that their son had demanded "a lot of attention when he was a young child but did not have any major problems."[59] As a result of Mr C's father's various army postings the family travelled extensively throughout Mr C's childhood. His parents reported that they had moved house 22 times in 27 years.

[59] Social Circumstances Report, 24 October 2005, p1

4.3 It was documented that Mr C recalled[60] one particular incident, when he was about four years of age and living in Germany, when he and two older children set light to a barn building. He reported that he had heard a voice telling him to kill someone and that he "saw the face of the devil."[61] Mr C's parents confirmed that this incident occurred but that no one was hurt and there were no criminal charges.[62]

4.4 From the age of six to the age of nine Mr C attended a boarding school. There is some contradictory information regarding why he left this school: Mr C reported that his parents removed him but in other reports we noted that it was documented that he had been expelled for allegedly making dangerous weapons.[63] Mr C explained that the school was situated in woodland and that he had made various weapons, such as catapults, axes and spears, from branches of the trees but that it had never been his intention to use them as weapons.

4.5 From this point Mr C attended various mainstream day schools in both Germany and England. Mr C took various GCSE examinations but only achieved low grades and he left school at the age of 17.

Training and employment

4.6 After Mr C left school he joined the army. However, he did not finish the initial training programme, leaving after four months. There were again several contradictory reasons documented regarding why Mr C left the army: he reported that he left because he had a "commandos tattoo on his arm and he was worried that if the army found out he would be put in prison",[64] as it was a "mark of death."[65] Whereas his family reported to us that they had encouraged him to leave due to their concerns about him having to fight in an impending war.

4.7 Following his discharge Mr C returned to the family home and began an apprenticeship, via a government training scheme, at an engineering company, where he obtained an NVQ qualification. Until September 1994 Mr C, despite his ongoing mental health symptoms, managed to continue working. It was documented[66] that the reason that he eventually gave up work was that he was "unable to get out of bed in the mornings."[67]

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[60] Social Circumstances Report, 24 October 2005, p1

[61] Social Circumstances Report, 24 October 2005, p2

[62] Social Circumstances Report, 24 October 2005, p2

[63] Social Circumstances Report, 24 October 2005, p3

[64] Social Circumstances Report, 24 October 2005, p3

[65] Social Work Report, 24 October 2005, p3

[66] Letter from consultant psychiatrist to GP, 11 August 1994

[67] Letter from consultant psychiatrist to GP, 11 August 1994

4.8 From 11 October 1995 the GP was issuing Mr C with sickness certificates, which initially cited depression as being the reason for him being unable to seek employment.

4.9 From this point onwards Mr C was unemployed. It was documented that after Mr C left his employment "boredom"[68] and his lack of socialisation with his peers were significant factors in the continued deterioration in his mental health. At times various CPNs were unsuccessfully attempting to engage him in various community and recovery activities.

4.10 In 2010 whilst Mr C was waiting for suitable accommodation to be secured he obtained a position at the medium secure unit's library.

4.11 At the time of the incident Mr C was in receipt of housing and sickness and disability benefits (DLA).

Relationships

4.12 Mr C reported that during 1996 to 1997 he had been in a long-term relationship.[69]

4.13 On 16 May 1998 Mr C was admitted to an inpatient unit, reporting[70] that he was in a new relationship and he had been due to get married that day but that the wedding had been cancelled. This relationship ended after this incident. There was also some documentation, within Mr C's clinical notes, indicating that he had been involved in other relationships, the last one noted as being in March 2013.

4.14 With regard to the friendships that Mr C had developed, from 1999[71] concerns were being expressed by both his family and various agencies that Mr C was considered to be vulnerable to exploitation from his friendships with members of the local drug-using community. It was repeatedly being assessed that due to his ongoing associations with these individuals, he was extremely vulnerable both in terms of his mental health and financial exploitation. At times his accommodation was at significant risk, as it was being used for illegal drug use.[72]

4.15 It was difficult for us to ascertain if Mr C had any children, as there were conflicting reports within the clinician notes. At times Mr C was reporting that he had fathered a number of children and during our interview with him he talked about a particular child whom he believed he was the father of and that he was concerned that he had no contact with this child.

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[68] Letter to GP from community consultant psychiatrist, 16 February 1994

[69] GP notes, 1 September 1997

[70] Discharge summary, 25 May 1998

[71] Substance Misuse Services Risk Assessment Summary, 20 October 1999

[72] Social Services Report to Mental Health Review Tribunal, 12 July 2002

4.16 Mr C's parents reported to us that they were not aware of the existence of any grandchildren. In 2010[73] a social worker documented that they had attempted to locate a number of children that Mr C had reported were his but that this search had been unsuccessful.

4.17 It is well documented that during Mr C's periods of being mentally unwell he was extremely thought disordered and that during such times he was often an unreliable self-historian. Based on the lack of evidence that both ourselves and the various professionals were able to obtain it is possible that Mr C's belief that he had fathered a number children was the result of his delusional thinking.

Arising issues, comments and analysis

4.18 As a military family Mr C's family was frequently required to relocate to known area of conflict. We obtained one report, completed during Mr C's admission to the medium secure unit (2008[74]), which considered the effects that this may have had on Mr C's childhood experiences and developmental progress. The report suggested that the probable prolonged absence of his father, due to his military duties, and the likely effects of Mr C's exposure to at least one posting, in Northern Ireland, where at the time acts of terrorism and violence were an everyday occurrence may have had a profound effect on Mr C. It was also suggested that it was possible that due to Mr C's early exposure to military life he may have developed, at a very early age, a "morbid interest"[75] in the use of weapons.

4.19 The report also suggested that Mr C's formative experiences in early childhood may have led him in adult life to be overly "guarded, suspicious and hypervigilant to possible danger."[76]

Physical health

4.20 We obtained Mr C's primary care notes from 25 January 1991 where it was documented that he was, at the time, taking Panoxol.[77] It is not clear as to why he was taking this supplement, as there was no indication that he had a history of heart disease.

4.21 At his initial patient registration with a primary care service (1991) it was documented within his family's medical history that his uncle had suffered a stroke. However, in 2012, during his registration with a new primary care

[73] Social Report for Managers' Hearing, 12 July 2010

[74] CPA Case Conference Psychological Therapy Report, 12 December 2008

[75] CPA Case Conference Psychological Therapy Report, 12 December 2008, p2

[76] CPA Case Conference Psychological Therapy Report, 12 December 2008, p2

[77] Supplement to improve cardiovascular health

surgery, it was noted that there was no family history of either heart disease or TIA.[78]

4.22 During Mr C's admission to a medium secure unit in 2006, it was documented that an ECG showed a right ventricular hypertrophy.[79] It is unclear if Mr C was at the time presenting with any symptoms, such as an elevated BP, nor was it documented in the subsequent discharge summary that was sent to his primary care service.

4.23 On 27 May 2009 paramedics were called to the unit as Mr C was experiencing chest pains. On examination his BP and pulse were within normal range and an ECG showed no significant pathology. Mr C was advised to reduce his cigarette smoking (he had admitted to smoking around 100 cigarettes a day) and to improve his dietary intake.[80]

4.24 In 2010 Mr C began to present with lower back pain a subsequent MRI scan (26 November 2010) reported that he had a slipped disc. He was initially treated with dihydrocodeine[81] (30mg) and then his pain relief medication was changed to tramadol.[82] During Mr C's last admission to a psychiatric inpatient unit (25 May 2013) there was some indication[83] that he may have been using tramadol more for its opioid effect rather than for pain relief.

Arising issues, comments and analysis

4.25 During our review of Mr C's primary care notes it was evident that the main issue that successive GPs were managing was Mr C's ongoing non-compliance with and his risk of abusing his medication regime and the potential risk of him stockpiling medication and overdosing.

4.26 Mr C's behaviour was also identified as causing concerns for the successive primary care services. As far back as1994 the primary care notes were repeatedly documenting difficulties in managing Mr C's repeated and at times aggressive demands for medications, especially Temazepam[84] and Diazepam.[85] It was documented that there was evidence that Mr C was misusing these highly addictive medications for recreational use. On several occasions the GP noted their concern that Mr C was at significant risk of

[78] TIA: Transient Ischemic Attack, mini-stroke

[79] Ventricular hypertrophy: when the muscle thickens around one of the heart's lower chambers, the thicker heart muscle loses
elasticity

[80] Information documented in a CPA Case Conference, 18 September 2009

[81] Dihydrocodeine opioid analgesic prescribed for pain. Can be addictive

[82] Tramadol: opioid pain-relief medication

[83] Interview with inpatient speciality doctor

[84] Temazepam: used to treat insomnia

[85] Diazepam: used to treat anxiety disorders, alcohol withdrawal symptoms, or muscle spasms

exploitation from others, as he was reporting that he had a fear "of going out and being assaulted by addicts for his medications."[86]

4.27 With regard to Mr C's behaviour at the various primary care services, there was one incident on 11 September 2003 where the police had to be called, as he had become verbally abusive to the receptionists demanding a prescription of Diazepam as he "was in withdrawal."[87] Following this incident Mr C was removed from the GP's patient list.

4.28 At one point there was an alert on Mr C's primary care notes that "no prescription should be dispensed until further notice."[88] In order to manage these concerns and Mr C's ongoing non-compliance from 21 July 2004 his prescriptions were sent directly to the pharmacy and dispensed to him on either a weekly or a daily basis. At other times such were the concerns about his ongoing non-compliance with his medication that his care coordinator were delivering and supervising him taking his medication on a daily basis.

4.29 At the time of the incident (11May 2013) Mr C was collecting his medication on a daily basis from a local pharmacy and therefore was taking it unsupervised. The care coordinator reported to us that he and the pharmacist were in frequent communication and that the pharmacist was also functioning as an additional monitoring agency who was notifying the care coordinator either when Mr C failed to collect his medication or if there were concerns regarding his presentation.

4.30 The GP in Solent, who was interviewed as part of our investigation, reported that they are invited to a patient's CPA[89] and safeguarding meetings but that it is not viable for them to attend. They do however receive copies of care plans which include any changes to a patient's risk or support needs or medication. We saw evident that following both Mr C's CPA reviews and discharges from the inpatient unit his GP was sent updated care plans which included some risk information.

4.31 The GP, who we interviewed, agreed that it would be helpful for the more complex patients, such as Mr C who are on an Enhanced CPA, that following a CPA review and where significant changes in the patient's risk factors or medication have been identified that the care coordinator should arrange to ideally meet with the GP at their surgery or if not feasible then by telephone, so that any changes can be discussed.

4.32 Following Mr C's move to the Solent area he registered with a new GP on 24 October 2012. It was reported to us that at this time primary care services in

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[86] 17 January 2012

[87] 11 October 2003

[88] 19 August 1998

[89] The Care Programme Approach (CPA) is a way that services are assessed, planned, coordinated and reviewed for someone with mental health problems or a range of related complex needs

the locality were not using compatible electronic patient records systems, so that when a patient initially registered only a summary of their medical records is forwarded by the previous primary care service and that it could take some time to obtain a patient's full medical records. We were, however, informed that currently all primary care services in the area are in the process of transferring to the electronic patient record system SystmOne[90] and that this will allow full access by all primary care services in the area to patients' medical records. This will enable a seamless transfer of medical care.

4.33 It was also reported to us by Mr C's last primary care service that although participation in NICE's Quality and Outcomes Framework (QOF) 2013/14[91] is a voluntary code of practice, they have recognised that patients with mental health issues are a vulnerable group, especially with regard to their physical health issues. Therefore, although they do not receive any funding allocation for this service, they offer annual health checks to this patient group. However, it was acknowledged that because of the transient nature of this particular patient group and the fact that they will often only seek primary care services when they are at a point of crisis, it is sometimes difficult to engage with them in relation to their ongoing physical health care needs.

4.34 Following the incident that occurred on 17 January 2013, when Mr C had been arrested for possession of an offensive weapon (knife) and for allegedly stalking a female shop worker, as part of his bail conditions an exclusion zone was placed around the area where his pharmacy was situated. His care coordinator reported to us that it "did not help when you have a patient with an enduring mental illness who has to walk a mile round to collect the medication. It didn't make things easy for him."[92] He also reported that the exclusion zone presented a significant challenge as he had to arrange another pharmacist, within an extremely short time frame, who was prepared both to dispense Mr C's medication on a daily basis and to be willing to provide some monitoring of both Mr C's compliance and his mental health. We could find no evidence to indicate that there had been any liaison or communication between the magistrates' court and the Criminal Justice Team (CJT) regarding the implications of the exclusion zone for the management of Mr C who it was known had such significant risk factors and also a history of non-compliance with his medication. We would suggest that the sudden imposition of an exclusion zone created some avoidable potential risks and that it should have been the role of the CJT to have alerted the magistrates' court and Mr C's legal team to the potential impact and risks of imposing this restriction of movement.

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[90] SystmOne is an electronic clinical system which supports a 'one patient, one record' model of healthcare. Using SystmOne, clinicians can access a single source of information, detailing a patient's contact with the health service across a lifetime. http://www.tpp-uk.com/products/systmone

[91] NICE website. QOF. http://www.nice.org.uk/aboutnice/qof/qof.jsp

[92] Interview with assertive outreach care coordinator, 12 June 2015

Recommendation 1: For patients on Enhanced CPA when there has been a significant change in either their risk factors or medication, which have been made at their CPA review or during an inpatient admission, their care coordinator should discuss with the GP the future management of the patient.

5 Psychiatric history

From 1991 to 2004

5.1 It was well documented in Mr C's medical notes that he began to exhibit mental health symptoms during his time in the army at the age of 17, which also appeared to have coincided with reports that he had begun to use illegal drugs.

5.2 However we were unable to locate any secondary mental health notes until 10 September 1991, when Mr C was 18, when he registered with a new GP surgery. During his initial consultation Mr C disclosed that he was taking amphetamines. After this appointment there were no records of Mr C until 29 July 1993, when he was admitted, initially on an informal basis, to a psychiatric inpatient unit. He reported that he had been experiencing increasingly intrusive thoughts relating to significant figures at the time, e.g. President Clinton. During this admission Mr C was involved in several serious incidents; he attacked another patient with a knife, he reported that he had been hearing voices on the television that had been telling him to kill this particular patient. On another occasion he reportedly threatened staff again with a knife.[93] After this first incident Mr C was placed on a section 2[94] and was diagnosed with "acute psychotic illness."[95] In a subsequent letter a forensic psychiatrist, who had assessed Mr C after the first incident, stated: "whether this was part of a schizophrenic illness only time will tell."[96] Six days later (19 August 1993), the same forensic psychiatrist assessed Mr C again and documented that he had become "more disturbed and more dangerous"[97] and was not responding to an increased dose of antipsychotic medication. The assessment concluded that Mr C required "treatment in greater security"[98] and recommended that he be transferred to a regional secure unit.

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[93] Letter from consultant forensic psychiatrist to locum consultant psychiatrist, 19 August 1993

[94] Section 2 of the Mental Health Act (1983), detained for up to 28 days for assessment and treatment

[95] Letter from consultant forensic psychiatrist to locum consultant psychiatrist, 13 August 1993

[96] Letter from consultant forensic psychiatrist to locum consultant psychiatrist, 13 August 1993

[97] Letter from consultant forensic psychiatrist to locum consultant psychiatrist, 13 August 1993

[98] Letter from consultant forensic psychiatrist to locum consultant psychiatrist, 19 August 1993

5.3 From the documentation available to us it appears that this transfer did not occur and after a period where Mr C became increasingly settled and compliant with his medication (Clopixol[99] 10mg and Procyclidine[100] 5mg), it was decided that he would be discharged to his parents' home (13 September 1993).

5.4 On 23 November 1993 Mr C took an overdose of 100 tablets of Flupenthixol.[101] Mr C reported that prior to the overdose he had not been experiencing any thought disorder or hallucinations but that he had been feeling very depressed. After a night of observations he was discharged from the hospital.

5.5 Mr C was admitted again to a psychiatric inpatient unit in August 1994. During this admission he was given a diagnosis of "depressed mood, nonspecific anxiety, and probable paranoid schizophrenia."[102] In 1998, whilst again in a psychiatric unit, he was diagnosed with an unspecific personality disorder with an acute psychotic episode, although it was noted that "the possibility of schizophrenia remained a differential diagnosis."[103]

5.6 We noted that from 1994, almost without exception, during Mr C's numerous psychiatric admissions his medication regime, i.e. various combinations of antidepressants and antipsychotic medications, was being continually adjusted. This was either in response to his requests, as he reported that he was unhappy with the various side effects that he was experiencing, his non-compliance or when it was assessed that they were having little or no effect on either his symptoms or his behaviours.

5.7 In 2002, again during an admission to hospital, where Mr C was initially detained under a section 2 which was subsequently converted to a section 3 of the Mental Health Act (1983), it was documented that he was presenting as objectively agitated and thought disordered with delusions of reference from the television. He was commenced on depot neuroleptic medication[104] which reportedly had some significant effect on his symptoms, although he continued to have angry and aggressive outbursts. It was assessed that although Mr C's life remained chaotic and he was continuing to use illegal

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[99] Zuclopenthixol (Clopixol) is a typical antipsychotic drug of the thioxanthene class

[100] Procyclidine is an anticholinergic drug (class of drugs that block the action of the neurotransmitter
acetylcholine in the brain) to reduce the side effects of antipsychotic treatment given for schizophrenia

[101] Antipsychotic medication

[102] Discharge summary, 7 October 1994

[103] Differential diagnosis: the process of weighing the probability of one disease versus that of other diseases possibly accounting for a patient's illness. Discharge summary, 26 January 1999

[104] Antipsychotic medication given by injection

drugs he was to be discharged with extensive support from community services.

5.8 He was next admitted in July 2003, when his neuroleptic medication[105] was changed to Pipothiazine Palmitate (75mg fortnightly IM).[106] The following diagnoses were confirmed during this admission: schizophrenia (paranoid type),[107] polysubstance induced psychosis and a mixed personality disorder with borderline and antisocial traits.[108]

5.9 After each discharge from hospital Mr C's care was transferred to the community mental health teams (AOT) but he frequently did not attend his scheduled appointments.

5.10 During periods when Mr C's symptoms were being relatively successfully managed, either while he was an inpatient or when he was living in the community, he consistently declined to engage either in psychological intervention or with substance misuse services.

Identified risk factors

5.11 We located a risk assessment from 1994 where it was documented that Mr C presented a significant risk to himself, although it was assessed that he was not actively suicidal.[109] It was also documented that although he continued to be experiencing persecutory anxiety, he was no longer keeping knives under his pillow.[110]

5.12 On 18 March 1999 Mr C presented himself at a police station, reporting that he was "going to kill people"[111] and that he wanted to be admitted to hospital. On 27 June 2001 he was detained by police on a section 136,[112] he was carrying a knife and was threatening to kill himself. During a subsequent forensic assessment[113] Mr C disclosed that he had bought a set of knives for his self-protection and that he had brought one into hospital. He denied any homicidal ideation but that he wished to remain in hospital as "if he goes back

[105] Antipsychotic medication

[106] IM: intramuscular site

[107] (ICD 10 F20.0)

[108] Report to the Mental Health Review Tribunal, 8 July 2002

[109] Letter from consultant psychiatrist to GP, 11 August 1994

[110] Letter from consultant psychiatrist to GP, 11 August 1994

[111] Discharge summary, 7 May 1999

[112] The police can use section 136 of the Mental Health Act to take you to a place of safety when you are in a public place. They can do this if they think you have a mental illness and are in need of care

[113] 30 November 2001

to (his) flat he might kill someone."[114] It assessed that Mr C had full awareness of the consequences of him carrying knives in the community.

5.13 A subsequent report to the Mental Health Tribunal Review[115] recommended that Mr C should remain in hospital, under a section 3 of the Mental Health Act (1983), as there was sufficient evidence to indicate that he was "an imminent danger to other patients and staff".[116] It also noted that serious consideration should be given to transferring him to a medium secure forensic facility but this did not occur.

5.14 During an admission the following year (13 May 2003) there were several incidents of Mr C being violent towards others and also of his repeated inappropriate and intimidating behaviours; for example he reported that he had "an urge to stab girls because they were sexually threatening towards him."[117] He also punched a member of the ward staff and started a fire in the grounds of the hospital. It was also documented that during this admission Mr C reported that a particular patient, whom he had known from a previous admission (2002), was making specific threats against him and that he was communicating to him through his tattoos. During this admission it was also noted that Mr C was leaving the unit and was thought to be injecting amphetamines. He was continuing to exhibit ongoing threats and acts of verbal and physical aggression and boundary violations.

5.15 Throughout this hospital admission Mr C's continued drug use and physical and verbal threats to staff and other patients were continually being identified as significantly high risk factors. It was assessed that despite there being periods where Mr C's symptoms were relatively controlled, it did not eliminate his significant risks to others as he was leaving the unit to obtain illegal drugs and alcohol. Given this assessment and various incidents that occurred, it was not evident to us why the discharge summary[118] from this admission identified that Mr C's risk of harm to others as being low.

5.16 During a subsequent hospital admission (May 2004) Mr C seriously assaulted a patient and a member of staff, which left them both with significant bite marks, cuts and bruises. It was documented that he continued to make threats towards named individuals and it was assessed that if Mr C had access to either his potential victim and/or weapons the risk to these individuals' safety would significantly increase.[119] In a psychiatrist's report (26

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[114] Letter from forensic consultant psychiatrist to community consultant psychiatrist, 30 November 2001

[115] Reference MHRT

[116] Mental Health Review Tribunal, 8 July 2002

[117] Letter from inpatient consultant psychiatrist to community consultant psychiatrist, 3 October 2003

[118] Discharge summary, 23 June 2003

[119] Letter from consultant forensic psychiatrist to inpatient consultant psychiatrist, 22 August 2004

July 2004) it was assessed that Mr C posed an ongoing threat to others and that his numerous extended periods of treatment either on an open ward or in a low secure setting had not been able to reduce this risk. It was also assessed that Mr C's ongoing mental health symptoms were treatment resistant and that he was displaying antisocial personality traits. He was convicted of ABH[120] for assaulting another patient. He was placed on a section 37 of the Mental Health Act (1983).[121] This was subsequently converted to a section 3[122] in 2005 reportedly due to "the paperwork being mislaid."[123]

5.17 At this point Mr C was a patient on a Psychiatric Intensive Care Unit (PICU) and on 12 January 2005, due to his continued aggressive behaviour, he was transferred to a medium secure unit.

From 2005 to 2012 (to the point of transfer to Solent mental health services)

5.18 Mr C was placed initially on the acute admissions ward in a medium secure unit and then on the intensive care ward. Throughout the first three years of this admission Mr C continued to exhibit florid psychotic symptoms. The main focus of this period was to try and stabilise Mr C's symptoms with various antipsychotic and mood stabilising medications, such as Depixol (Flupenthixol),[124] Lithium Carbonate[125] and Sodium Valproate.[126] Due to Mr C's presentation of symptoms of mania, his diagnostic formulation was adjusted to a schizoaffective disorder.[127]

5.19 On 31 May 2005 Mr C made what was considered to be a serious suicide attempt. He attempted to hang himself from his bedroom window, reporting

[120] ABH: actual bodily harm

[121] The criminal courts can use a section 37 if they think a person should be in hospital instead of prison. Section 41 is a restriction order. The Crown court can add this order to a section 37 if they have concerns about public safety and a person's level of risk

[122] Section 3: detained for up to six months at which point it has to be renewed for a further six months and subsequently on a yearly basis

[123] Mental Health Review Tribunal Report, 1 July 2007

[124] Depixol (Flupenthixol): antipsychotic medication

[125] Lithium Carbonate: mood stabiliser used to treat manic-depressive disorder (bipolar disorder)

[126] Sodium Valproate: mood stabiliser used in treating mania in people with bipolar disorder and all forms of epilepsy

[127] Schizoaffective disorder is a serious mental illness that has features of two different conditions -- schizophrenia, and an affective (mood) disorder that may be diagnosed as either major depression or bipolar disorder

that he had done this in response to hearing derogatory and threatening auditory hallucinations.

5.20 Through the five years Mr C was an inpatient at the medium secure unit there were numerous occasions when he physically assaulted and made verbal threats towards both staff and other patients. On 22 April 2005 police also contacted the unit[128] to report that Mr C was making telephone calls to his ex-girlfriend in which he was threatening to kill her.

5.21 It was also suspected that Mr C was continuing to access illicit substances and a drug test (3 July 2005) tested positive for cannabis. The next test was negative and thereafter Mr C refused all drug screening, although there were ongoing suspicions that he was continuing to use illegal drugs. It was also documented that several times Mr C stole medication from the ward's medication cupboard and there were occasions when he extorted medication from other patients.

5.22 During early 2006 Mr C's symptoms became increasingly floridly psychotic and he seriously assaulted another patient. As he was not responding to his medication regime of Olanzapine (30mg daily), a request was made (28 February 2006) for a Second Opinion Appointed Doctor's[129] (SOAD) assessment as it was assessed that Mr C lacked the capacity to consent to being prescribed an increase to 40mg daily of Olanzapine. This dose was one and a half times the BNF[130] recommended dose of Olanzapine. The SOAD approved this increase.

5.23 During 2007 Mr C's symptoms and his behaviours continued to deteriorate further, and following another SOAD's assessment, his mood stabiliser was changed to Semisodium Valproate[131] and Depakote[132] 750mg.

5.24 After this adjustment to his medication Mr C's symptoms began to settle and he was transferred to a lower dependency ward. However, there were many documented instances when he was refusing his medication which often

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[128] 22 April 2005

[129] A registered medical practitioner appointed by the Mental Health Act Commission (a Second Opinion Appointed Doctor or SOAD) must certify when giving a certificate under section 57 (treatment requiring consent and a second opinion) and section 58 (treatment requiring consent or a second opinion) of the 1983 Act authorising the giving of certain types of medical treatment for mental disorder. http://www.legislation.gov.uk/ukpga/2007/12/pdfs/ukpgaen_20070012_en.pdf

[130] BNF: British National Formulary provides up-to-date guidance on prescribing, dispensing and administering medicines. It details all medicines that are generally prescribed in the UK, with special reference to their uses, cautions, contra indications, side effects, dosage and relative costs. The BNF reflects current best practice as well as legal and professional guidelines relating to the use of medicines

[131] Semisodium valproate is used as a mood stabiliser in bipolar disorder

[132] Depakote: treatment for epilepsy, or bipolar mania

resulted in him experiencing periods of elated moods and continued incidents of aggression towards other patients and staff at the unit.

5.25 By 2008 both his CPA reviews (11 January and 2 May 2008) and MDT[133] meetings agreed that the focus of Mr C's treatment needed to be working towards a gradual discharge plan but that this would require him to be actively engaging in a rehabilitation programme. It was also agreed that his initial community placement should be a 24-hour staff facility. The initial phase of this process was to transfer him to the discharge ward. However, Mr C's continued aggression towards staff and other patients and his repeated non-compliant behaviours with regard to various ward rules prevented this occurring.

5.26 On 6 May 2009 a SOAD again reviewed Mr C's Olanzapine medication due to him experiencing extrapyramidal side effects.[134] This assessment concluded that various tests had indicated that there were no underlying physical issues and that based on the assessment from the psychiatric team Mr C was suffering from treatment resistant schizophrenia and although he was functioning reasonably well on his current medication regime he was still experiencing residual features of his illness. The SOAD also concluded that Mr C's current treatment plan had made his symptoms "less intrusive and has assisted with his rehabilitation plans"[135] and that "the treatment is appropriate and beneficial … it is unlikely to cause serious harm to physical or mental health."[136]

5.27 From 2008 physiologists were recommending that a structured care pathway should be identified in order to support and manage Mr C's move towards initially a less secure environment (i.e. a rehabilitation ward) and then ultimately to a discharge into a community supported housing scheme. It was suggested that this pathway "may encourage him to become more compliant with treatment and provide him with an aim that will increase his motivation to engage with his care plan."[137]

5.28 By July 2009 a suitable move-on scheme had been identified but due to a reported "clerical issue" [138] which resulted in the referral application being mislaid Mr C lost this placement and he remained on an acute ward for another six months. On 23 February 2010 Mr C was transferred to the unit's rehabilitation ward, where he continued to wait for a suitable placement to be secured. It was reported[139] that the effects of the protracted delays in securing

[133] MDT: multi-disciplinary team

[134] Extrapyramidal side effects physical symptoms, including tremors, slurred speech, and akathisia (inability to sit still)

[135] Form T3 Section 58(3) (b) certificate of second opinion, 6 May 2009

[136] Form T3 Section 58(3) (b) certificate of second opinion, 6 May 2009

[137] CPA Case Conference, 11 January 2008

[138] CPA Case Conference, 19 March 2010, p5

[139] CPA Case Conference, 19 March 2010, p5

Mr C suitable move-on accommodation had caused him "considerable distress and periods of low moods"[140] and that his behaviour again deteriorated to the point where both patients and staff were reportedly finding him intimidating. Due to his continued threats and attacks on other patients several referrals were made to the hospital's safeguarding panel (April and May 2010). During one period, in order to try to minimise Mr C's "dissocial behaviour"[141] 15-minute observations were introduced and several times either his ground leave or escorted community leave was suspended.

5.29 Mr C finally moved out of the unit into a high supported housing scheme, initially on section 17 leave, on 22 November 2010 (please refer to housing section). Mr C's section 3 was discharged on 15 December 2010 and his care was transferred to Southern Health's AOT and a CPN from the team was his care coordinator. His clinical care was transferred to Southern Health's community outpatient consultant psychiatrist and he was also receiving intensive support from a key worker at the scheme.

5.30 Mr C's discharge medication was Diazepam 10mg, Olanzapine 40mg daily, Procyclidine 5mg bd and Dihydrocodeine 60mg qds. We reviewed evidence of correspondence from the inpatient forensic clinical team to Mr C's new GP and community psychiatrist, where the rationale of Mr C's discharge medication was outlined. In the letter to the GP, it was documented that "in my opinion … this combination of medication has allowed (Mr C) to be safely discharged from hospital and manages his risk behaviour. It is my recommendation that he continues on Diazepam 10 mg tds and Olanzapine 40 mg daily."[142]

Risk assessment and care planning

5.31 After Mr C's transfer to a medium secure unit in November 2005 it was assessed that "his continued risk of violence combined with his on-going illicit substance misuse, non-compliance with treatment and what appears to be treatment resistant schizophrenic illness"[143] meant that his continued detention in a medium secure unit was necessary for the "health and safety"[144] of Mr C and also for the "protection of other persons." [145]

5.32 A Mental Health Tribunal Review report indicated that if Mr C was not detained he would seek to leave the hospital and "present an immediate risk to members of the general public."[146] His risk to himself and others was assessed as being high, and these risks significantly increased during his

[140] CPA Case Conference, 19 March 2010, p5

[141] Managers' Hearing, 12 July 2010

[142] Letter from consultant forensic psychiatrist to GP, 7 December 2010

[143] Mental Health Review Tribunal Report, 1 July 2007

[144] Mental Health Review Tribunal Report, 1 July 2007

[145] Mental Health Review Tribunal Report, 1 July 2007

[146] Mental Health Review Tribunal Report, 1 July 2007

more acute psychotic periods, when he experienced persecutory delusions and command auditory hallucinations.

5.33 In March 2007, due to Mr C's increasing assaults, theft of medication and inappropriate sexual behaviours on the ward, it was decided at a ward round that any further assaults would, from that point, be brought to the attention of police and should be dealt with by the criminal justice system. From this point, whenever there were incidents of violence or intimidation, they were reported to the police who carried out an investigation and, where deemed appropriate, criminal charges were brought against Mr C.

5.34 Although there were numerous references, within successive Mental Health Tribunal Reviews, to Mr C's risk factors, we were only able to locate one completed risk profile (23 June 2009). This profile comprehensively details all the incidents from 2001 and their antecedents. It noted that incidents of violence were usually either preceded by an argument or threats towards individuals who were linked in some way to Mr C's psychotic and delusional thinking or in response to what he perceived to be provocation from others. It was assessed that in such situations Mr C was more likely to use physical force, e.g. punching, and that his previous use of weapons had been "opportunistic."[147] It was also clearly and repeatedly documented that Mr C had a known history of knife possession.

5.35 This risk profile also identified that the potential risk factors of Mr C moving into a less secure community environment were high as he would have access to illegal substances. Also that based on Mr C's history, this would more than likely lead to non-compliance with prescribed medication and to antisocial and challenging behaviours. Although it did note that since Mr C's admission to the medium secure unit the number of episodes of violence had been gradually decreasing and that in the last 12 months there had been no incidents. Although he was still making occasional threats towards individual patients and staff. It was also documented that Mr C consistently refused to engage in any substance-misuse programme and that he only had limited insight into his mental illness.

5.36 The risk profile also suggested that the protective factors and monitoring arrangements to manage Mr C's known risks in the community should include regular mental state examinations, on-going monitoring of his compliance with medication and support from community mental health services. It also noted that community services would need to establish a good therapeutic relationship with Mr C and be responsive to his known risk indicators. It also suggested that consideration should be given to offering Mr C cognitive behavioural therapy (CBT) although it was acknowledged that historically Mr C had been reluctant to engage in any form of psychological therapeutic interventions.

[147] Risk Profile, 23 June 2009

5.37 The profile concluded that if Mr C were to be discharged into a residential setting he should be subject to a Community Treatment Order (CTO)[148] with the conditions that he must fully engage with his community psychiatric team and abstain from illegal substances and alcohol. We noted that a CTO was not part of Mr C's discharge plan and that the inpatient unit quickly withdrew their involvement on 15 December 2010. He was placed on an Enhanced CPA. When we asked why a CTO was not put in place we were informed that it was not felt to be necessary as Mr C was accepting the treatment plan that was being proposed, i.e. his accommodation, was compliant with his prescribed medication regime and the support being provided by AOT and the supported housing scheme. Additionally Mr C had been successfully managing his S17 leave prior to moving into the scheme.

5.38 During Mr C's five year admission to the medium secure unit we saw documented evidence of regular Mental Health Tribunal reviews and CPA case conferences. Both extensively documented his progress, the incidents of violence, his symptoms and decisions relating to his clinical management. We also noted that all of the CPA reviews included comments from both Mr C and members of his family.

5.39 Mr C's discharge risk summary identified two main risk factors: his risk of bullying and intrusive behaviour was assessed as being low. More significant was the risk of violence or aggressive behaviour if Mr C disengaged with mental health services, stopped taking his medication and returned to illegal drug use. If such a situation developed the management plan indicated that Mr C was to be admitted to a PICU, and that if he required longer-term treatment he should be transferred back to a medium secure unit. Another significant risk factor which began to be identified when Mr C moved into his own accommodation was his continued vulnerability and association with individuals from the local drug fraternity. Mr C's parents reported to us that the local police were aware of this issue and were monitoring the situation, although his care coordinator reported to us that he had not been unaware of this arrangement.

From March 2012 to January 2013 and the management of the transitional phase

5.40 By March 2012 it was being reported,[149] by the supported housing scheme staff, that Mr C was becoming increasingly aggressive and intimidating towards staff, especially female staff members. There was also an incident on

[148] Community Treatment Order (CTO): if a patient has been in hospital under a section 3, as part of the discharge planning they can be placed on a CTO. This means that a patient will have supervised treatment when they are discharged from hospital. It includes compliance with treatment, accommodation, etc. If a patient breaks any conditions of their CTO or the responsible clinician thinks that the patient is becoming unwell, they can be recalled. Once in hospital, the patient can be kept for up to 72 hours while it is decided what should happen next

[149] RiO notes, 7 March 2011

7 March 2011 when Mr C made threats to kill a neighbour. The police were called but no charges were brought but he was given a verbal warning by the attending police officers. There was also suspicion that Mr C had begun to use the legal high Red Dove,[150] which he subsequently confirmed was correct.

5.41 Staff at the supported housing placement were finding it increasingly difficult to support Mr C and on 10 March 2012, following a mental health assessment, he was admitted to a PICU under a section 2 of the Mental Health Act (1983). On 5 April 2011 his section was changed to a section 3 and his tenancy was subsequently terminated.

5.42 Despite extensive inquiries we have been unable to locate either clinical or RiO notes[151] from this admission. However, there was a discharge summary sent to the GP (29 December 2011), and we did locate a risk assessment (30 October 2012) undertaken during this admission. The discharge summary documented that Mr C's discharge medication was Olanzapine 10mg QDS, Procyclidine 5mg BD, Omeprazole 20mg OD, Diazepam 10mg QDS and Tramadol 50mg QDS.

5.43 Mr C's parents reported to us that due to the considerable delay on the part of statutory services in finding their son suitable accommodation, they secured him private rented accommodation. When Mr C moved into this flat he was again supported by the AOT. His care coordinator reported[152] that the team were visiting Mr C daily both to deliver his medication and to monitor his mental health. Additionally the AOT were supporting Mr C to develop his social skills and to manage his levels of anxiety when he was out in public situations.

5.44 It was reported to us[153] that during this period Mr C had insight into his mental health and that he was considered to be at low risk regarding the misuse of illegal drugs and harm to others. It was documented within Mr C's RiO notes that members from the AOT had, on occasions, seen a penknife on the coffee table in Mr C's flat. When they questioned Mr C as to why he had a knife he reported that it was there "if I was paranoid"[154] but that he was not taking it out with him. We noted that this was not referred to in any risk assessment that was undertaken during this time.

5.45 It was also reported[155] to us that up until the point Mr C moved to Solent his mood and mental health appeared to be very stable and he was fully compliant with his medication.

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[150] RiO notes, 10 March 2011. Red Dove is a legal high

[151] RiO: patient electronic records system used by many NHS Trusts

[152] Interview with care coordinator from Southern Health AOT

[153] Interview with Southern Health AOT care coordinator

[154] Interview with Southern Health AOT care coordinator

[155] Interview with Southern Health AOT care coordinator

5.46 However Mr C's father reported to us that they had increasing concerns about their son's ongoing association with local individuals and that they had felt he was very vulnerable to harassment and illegal drug use. Such was their concerns that they agreed with Mr C that he should move out of the area and they then secured him a tenancy in a private rented flat in the Solent area. Mr C's parents also reported to us that they were aware that this move would mean that all of their son's support services would have to transfer to Solent mental health services. But such were their increasing concern about their son's vulnerability and safety in Havant that they had felt that the disruption was necessary and unavoidable.

5.47 The exact date that Mr C moved into his new accommodation was not clear to us, as there are contradictory dates within the RiO notes. However, based on the documentation that was available to us his address in the Solent area was being documented from July 2012, so we have assumed that this was the month he moved.

5.48 Immediately prior and during the subsequent months after Mr C moved there were a number of instances where Mr C tried to harm himself and was admitted to hospital. On 8 June 2012 Mr C presented himself at the offices of the AOT, reporting that he had been stockpiling his medication. Upon leaving the office he took an overdose and was admitted to hospital. On 27 July 2012, Mr C was admitted to hospital having taken an overdose of tramadol (28 tablets), which he reported he had obtained from the emergency GP service. After he was admitted to the observation ward, staff contacted Southern Health's AOT in order to obtain background information regarding Mr C. Based on their observations of Mr C and also the information they had ascertained they assessed that Mr C did not pose any further suicide risk and he was discharged.

5.49 On 10 October Mr C was admitted to a psychiatric unit via A & E after he had cut his neck with a piece of glass. He reported that he had been drinking alcohol prior to the incident and that he had been told to harm himself by the voices that he was hearing.[156] A risk assessment was completed during this admission (30 October 2012), where it was documented that whilst on home leave Mr C had contacted the police who reported that when they had visited him he had informed them that he had taken heroin and that they had also observed evidence of heroin use in Mr C's flat . Mr C later denied that he was using heroin. Despite this incident being documented we noted that in a subsequent risk assessment Mr C's current risk of substance misuse was identified as being low.

5.50 It was documented that during this admission Mr C had on occasions intimidated other patients into giving him their medication and that he was often aggressively demanding from the ward staff his prescribed benzodiazepine medication. It was noted in a risk assessment that was undertaken during this admission that Mr C's "risk to others worsened by his psychotic symptoms including the presence of persecutory delusions and

[156] Information taken from Presenting Situation in RiO notes, 10 October 2012

command auditory hallucinations. There was also a link to the use of alcohol and illicit substances and his frustrations at not having his needs met."[157]

5.51 Based on the documentation that was available it appears that the initial transfer request from Southern Health AOT to Solent AOT was made on 7 November 2012. An initial assessment and handover meeting was scheduled for 23 November but was cancelled by Solent AOT. There was a note in the referral pathway checklist[158] which stated that this meeting was to be rearranged, but practitioners from Solent AOT reported to us that this meeting did not occur.

5.52 Southern Health's AOT continued support Mr C until 10 January 2013 and were initially visiting him daily and delivering his medication and supporting Mr C to register with a new primary care service and dentist. They then set up an arrangement with a local pharmacy for Mr C to collect his medication on a daily basis.

Arising issues, comments and analysis

5.53 We noted that there were two recurrent issues that were repeatedly being highlighted during the course of our interviews with various practitioners from both Southern Health and Solent mental health services: firstly, the management of the transfer of Mr C's care from Southern Health's mental health services to Solent's AOT; and, secondly, the issues relating to the transfer of Mr C's RiO notes from Southern Health NHS Foundation Trust.

5.54 **The management of the transfer of Mr C's care to Solent NHS Foundation Trust:** it was reported to us[159] that despite the extensive involvement of Southern Health's AOT, the actual transfer occurred when Mr C's care coordinator was on holiday. We were unable to ascertain why the transfer occurred at this point as the service manager from the AOT is no longer in the post and there was no documented evidence available. It was reported to us by members of Solent's AOT that the transfer of Mr C's care was "fairly abrupt"[160] and that there had not been a formal care planning meeting therefore there had been a number of unresolved issues. For example, Mr C had not been reviewed by the community psychiatrist from Solent and the arrangements for the dispensing of the prescription and collection of Mr C's medication from a pharmacy had yet to be resolved. It was reported to us that this lack of planning was felt to be especially concerning to the allocated care coordinator from Solent AOT as he was aware from his previous knowledge of Mr C that he had both complex needs and multiple high risk factors.

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[157] Risk assessment, 30 October 2012, p3

[158] 23 November 2012

[159] By care coordinators from both Southern Health and Solent and also a manager of Solent AOT

[160] Interview with Solent care coordinator

5.55 **The transferring of notes**: without exception all the practitioners from Solent mental health services (AOT and the inpatient unit), who were interviewed, repeatedly highlighted a historic systemic issue regarding the lack of sufficient information being transferred when a patient moves from Southern Health to Solent's services. It was explained to us by the Solent practitioners and senior managers that at one stage there was a system in place called RiO to RiO, where a certain amount of information about a patient could be accessed by the other Trust (i.e. either Solent or Southern Health). All agreed that this had been very helpful in the management of patients whose care was being transferred.

5.56 We were informed that this functionality is no longer available and that Solent are also currently in the process of procuring and implementing a new electronic patient records system, (SystmOne). This new system will not have functionality for sharing information with other Trusts. However since this incident Solent NHS Trust has introduced a Protocol for Receiving and Referring Transfers of Care between Solent NHS Trust and External NHS Organisations (this protocol is discussed further in section 11). We would recommend that an audit exercise is undertaken of a transition of a patient with similar complex need in order to evaluate this protocol's effectiveness.

5.57 It was reported to us that Southern NHS Foundation Trust's normal procedure in the transfer of a patient to Solent would be to send across a set of a patient's paper notes (referred to as "Orange Notes"[161]) at the point of transfer and that this would include risk assessments and support plans. Without exception it was reported to us by Solent clinicians that this did not occur. However, during the course of our review of Solent's notes, we found evidence within their risk assessments that they had access to some information from Southern Health NHS Foundation Trust regarding Mr C's previous risk history. We can only assume that this was either obtained via the RiO to RiO functionality or provided by Southern Health's AOT during the transfer process.

5.58 Several Solent clinicians whom we interviewed reported to us that that due to the lack of adequate referral information and historical medical history being available to either Solent AOT or during Mr C's three inpatient admissions,[162] they were having to rely on information supplied by Mr C and also by staff who had historical knowledge of him to inform their assessments and judgements.

5.59 One Solent clinician whom we interviewed reported that it would have been "particularly useful"[163] if he had had full access to Mr C's psychiatric history, especially from his period in the medium secure unit, in order to inform his clinical judgements. He also reported that he had been unaware of the

[161] Interview with care coordinator

[162] 30 January to 19 February 2013, 22 February to 5 March 2013 and 4 April to 25 April 2013

[163] Interview with inpatient consultant

dosage and the rationale behind the high levels of Olanzapine that Mr C had been prescribed during this period. The lack of historical clinical information being available and the issues that we have identified, particularly in regards to the transfer process between the two Trusts did cause us some concern. As with any patient such as Mr C who has a complex and challenging psychiatric history, it would seem essential, in order to provide continuity of care, that such a transfer is managed seamlessly. This must include the transfer of all medical and social care notes before the responsibility for care is assumed by the new Trust's services and it should be the responsibility of clinicians from both Trusts to ensure that this process is managed appropriately. We would suggest that in order for Solent NHS Trust to identify if the lack of historical reviews being undertaken for patients is a systemic issue within the inpatient unit they should undertake an audit of a selected number of patients' notes.

Recommendation 2: Where there is a planned transfer of a patient between NHS Trusts the responsible clinician must ensure, wherever possible, that the transfer of medical records is completed before they accept responsibility for the patient's care.

Recommendation 3: A full review of a patient's historical medical notes must be undertaken by both inpatient and community services as part of their initial clinical and risk assessment.

6 January 2013 to May 2013 (events leading up to the incident on 11 May 2013)

6.1 On 9 January 2013 Mr C called an ambulance, reporting that he had taken an overdose of LSD and amphetamines. During his assessment by the A&E Mental Health Liaison Team, it was documented that Mr C had reported that he had been in his flat when two associates whom he had previously known arrived and asked him for money so that they could buy drugs. He also reported that they had given him some pills which were a combination of LSD and amphetamines.[164] Mr C denied that he had taken an overdose. During discussions[165] between Solent AOT and the hospital's Mental Health Liaison Team it was suggested that this incident was probably a reaction to the transition between services that was taking place. Therefore it was likely that Mr C was attempting "to sabotage the transfer by doing all sorts of things i.e. calling police, ambulances however the transfer is still going ahead as planned."[166] Mr C was discharged into the care of Solent AOT.

6.2 After this discharge Mr C's care coordinator made two failed attempts to see Mr C (15 and 16 January) at his home. On 17 January Mr C was arrested for

[164] Information taken from Presenting Situation and Referral Outcome Decision, 9 January 2013

[165] 9 January 2013

[166] Presenting Situation and Referral Outcome Decision, 9 January 2013

possession of an offensive weapon (knife) in a public place and for allegedly stalking a female shop worker (see Section 9 for further details). Mr C was seen in police custody by a member of the Criminal Justice Team (CJT), who undertook a core assessment which included a risk assessment. The assessment documented that Mr C appeared to be lucid but he was reporting that he had been experiencing auditory hallucinations and was feeling suicidal, although he was not able to articulate any plans. Mr C also reported that he had drunk a bottle of vodka the previous day. However, it was noted that there was no evidence that he was intoxicated when he was arrested.

6.3 Mr C was released on bail with an exclusion zone in place that prevented him from approaching the shop where his alleged victim worked. As we have already stated this prevented him from accessing the pharmacy where he had been collecting his medication. Therefore, his care coordinator had to make an emergency arrangement with another pharmacy in order to maintain the continuity of provision of Mr C's medication.

6.4 Mr C was then admitted to an acute psychiatric unit on 30 January 2013 after he had been found near a naval base in full combat uniform. He was presenting in a psychotic state and it was thought that he had taken MDMA.[167] Mr C remained an informal patient at the unit until 19 February.

6.5 The details of events during this admission are fully outlined in the chronology (Appendix C). Briefly, Mr C presented throughout this admission with intermittent episodes of thought disorder, bizarre speech and responding to visual and auditory hallucinations. During the initial phase of this admission there were several incidents where Mr C displayed both aggressive and intimidating behaviour to staff and other patients. There was an incident (31 January 2013) where Mr C head-butted a member of staff, kicked a door and refused to allow staff to exit the room, stating that it was his intention to kill someone.[168] There were also a number of incidents where it was reported that Mr C was overly familiar towards female members of staff.

6.6 During this admission it was generally reported that Mr C utilised his leave from the ward appropriately and that staff were able to complete the appropriate risk assessments prior to his leave. However there were several occasions where he either went AWOL[169] or did not return at the agreed time. There was also one incident (11 February) when Mr C was on leave where he presented himself to A&E with what was reported as alcohol poisoning, he was subsequently transferred back to the inpatient unit.

6.7 During this admission it was reported that Mr C was regularly refusing his medication (Olanzapine) and also that he was repeatedly requesting that his medication be either changed or the dosage increased.

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[167] MDMA: ecstasy

[168] Information taken from Ward Review and Care Planning Meeting, 5 February 2013

[169] AWOL: absent without leave

6.8 At the Discharge and Care Planning Meeting (19 February 2013), at which Mr C's care coordinator from AOT was present, it was documented that the previous day Mr C had informed staff that he would no longer be accepting any medication. It was also documented[170] that Mr C did not want to be discharged, "stating that he would collapse as he had not eaten or drunk for the past 24 hours."[171] However, the discharge went ahead and he was discharged to the care of the AOT on a seven-day follow-up schedule (as per Trust policy).

6.9 Due to Mr C's ongoing risks of overdosing and of stockpiling medication he was only discharged with two days' supply of medication. His discharge medication was Omeprazole 20mg mane, Tramadol 50mg QDS, Diazepam 10mg QDS, Procyclidine 5mg BD and Quetiapine 200mg BD. The following diagnoses were reported in his discharge summary to the GP: Dissocial Personality Disorder (code F602), mental and behavioural disorder due to multiple drug use and use of other psychoactive substances (F195) and paranoid schizophrenia (F200).

6.10 The discharge summary also documented that Mr C's current risk factors included risk to females, details of his recent arrest, his pending charges and details of the exclusion zone were noted.[172]

6.11 Two days after this discharge (21 February), Mr C presented himself at a NHS Treatment Centre[173] where it was documented[174] that he had collapsed in the main reception area, reporting that he had taken an overdose of tramadol and had inflicted superficial cuts to his wrists. He reported that he had not eaten or drunk anything since his discharge from the inpatient unit (19 February). Mr C was diagnosed with severe dehydration, which required intravenous fluid for 16 hours. The admitting doctor assessed that Mr C was "too vulnerable to be nursed in the community at present as it would cause multiple agency issues and increase his risk."[175] He was transferred to the psychiatric inpatient unit (22 February).

6.12 Mr C was due to appear in court the following day (22 February 2013) but it was assessed that he was unable to attend. It was reported[176] to us that the impending court case continued to cause Mr C considerable concern and anxiety and was cited as being one of the contributory factors to his mental health during this and subsequent hospital admissions from January 2013.

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[170] CPA Episode Information, 18 February, completed by care coordinator from AOT

[171] CPA Episode Information, 18 February, completed by care coordinator from AOT

[172] Discharge summary, 21 February 2013

[173] Minor injury unit

[174] Discharge summary, 21 February 2013

[175] Presenting Situation & Referral Outcome Decision, 22 February 2013

[176] Interview with inpatient consultant psychiatrist

6.13 Following the transfer to the psychiatric unit a physical monitoring assessment was completed (22 February), which included a Malnutrition Universal Screening (MUST). We were not able to locate any further documentation that referred to any ongoing monitoring of Mr C's dietary and fluid intake during this admission, nor could we ascertain if a referral to a dietitian was considered.

6.14 On 25 February it was documented that there had been a number of instances where Mr C was verbally and physically confrontational and threatening towards staff and other patients. Both staff and the Speciality Doctor, who was on the ward at the time of one of these incidents, warned Mr C that if his behaviour continued he would be discharged from the unit.

6.15 Following the Ward Review and Care Planning meeting (5 March 2013) Mr C was discharged back to his accommodation. At this meeting it was documented that Mr C had reported that he had stopped drinking alcohol.

6.16 After Mr C was discharged there were several occasions where it was documented that his father was reporting to the CJT worker his ongoing concerns about his son's increasingly chaotic behaviour. He also reported to both the care coordinator and the CJT worker[177] that his son had given his flat keys to a homeless man and that he was unconvinced that he was taking his medication. He also voiced his concerns[178] that his son was still being prescribed Tramadol in light of the previous incident when he had overdosed on this medication.

6.17 On 15 March 2013 Mr C presented himself at his GP's practice, asking for an additional prescription of Diazepam. The GP refused this request.

6.18 During the next four weeks there were repeated instances[179] when Mr C failed to attend his scheduled visits with both his care coordinator and his CJT worker. Mr C's care coordinator only actually managed to see Mr C on one occasion (20 March 2013), although he had two telephone conversations with him on 17 and 18 March. On one occasion when the care coordinator spoke to Mr C, he reported that he had recently begun a relationship and that this was the reason that he had been missing his appointments. However, by 4 April Mr C was reporting that this relationship had ended.

6.19 On 4 April the pharmacist contacted the care coordinator to report that Mr C had not collected his medication since 26 March. Mr C's parents called the care coordinator to report their concerns about their son's behaviour at a recent family event. Later that day, Mr C presented himself to A&E in an acutely psychotic state.[180] There was also some concern that he may have taken either an overdose or legal highs and he had a significant wound on his

[177] 18 March 2013

[178] 8 March 2013

[179] 12 March, 14 March, 27 March, 4 April

[180] MH1 Assessment, 4 April 2013

right hand which had 17 sutures; it was thought that he had sustained this injury within the previous three days.

6.20 Mr C was observed by ward staff visibly responding to hallucinations and his speech was reportedly incoherent. The hospital's security also had to prevent Mr C from leaving the hospital until a mental health assessment could be completed. The assessment concluded that Mr C was a high risk to others and that his risk history indicated that "when he is experiencing this level of psychosis he is at risk of responding to command hallucinations ... telling him to harm himself and others."[181] Mr C was detained under section 2 of the Mental Health Act (1983).[182] The assessing doctor contacted Mr C's parents and it was documented that they had expressed relief that their son was being admitted.

6.21 A HoNOS[183] assessment completed the following day which identified the following issues as either moderate or severe: non-accidental self-injury, problem drinking or drug taking, cognitive problems, and problems associated with hallucinations and delusions.

6.22 This admission followed a similar pattern as the two previous admissions, i.e. incidents of verbal and physical aggression towards staff and fellow patients, occasions when Mr C went AWOL and returned to the unit either intoxicated or suspected of being under the influence of either illegal drugs or legal highs. During this admission there were two occasions[184] when the inpatient psychiatrist wrote to the magistrates' court to inform them that in their opinion Mr C remained too unwell to attend his scheduled court hearings.

6.23 Mr C was discharged from his section 2 at a ward round on 23 April and then subsequently discharged from the unit on 25 April 2013. His discharge medication was Omeprazole 20mg, Procyclidine 5mg, Quetiapine 100mg and Diazepam 10mg.

Care planning

6.24 It was reported to us that when Mr C was referred to the Solent AOT he was allocated a care coordinator who had previously known him as it was felt that their previous relationship may assist in establishing a working alliance. Additionally, due to Mr C's ongoing issues with female staff it was felt that it would be more appropriate for a male care coordinator to be allocated.[185]

6.25 The care coordinator reported to us that when he took over the care of Mr C he did not think that he had changed since their last encounter either in his

[181] MH1 Assessment, 4 April 2013

[182] Detained for up to 28 days

[183] HoNOS Health of the Nation Outcome Scales is not a risk assessment. 12 scales on which service users with severe mental illness are rated by clinical staff

[184] 8 April and 12 April

[185] Information obtained in interview with Solent AOT care coordinator

presentation or with regard to his ongoing issues in terms of both his symptoms and his social care needs. The care coordinator recalled that he saw his role as being "to stabilise him on his medication and to ensure that his risks were monitored and documented, to try and engage him in supportive services outside of mental health, i.e. substance misuse services. Also to try and engage him with local mainstream contacts because he had identified that he felt totally isolated in this new area."[186] Mr C was also allocated a Star support worker whose role was to support him to develop his social and domestic skills.

6.26 An initial care plan was written by his care coordinator on 10 January 2013, which was a continuation of Southern Health AOT's care plan. The plan identified both short- and long term support needs and goals in relation to supporting Mr C to live in the community. The care plan also identified the challenges that both Mr C and members of the AOT were facing in order to support him to become integrated into the new locality.

6.27 The other significant ongoing issue that the care coordinator reported was a significant issue was the coordinating of the arrangements with both the GP and the local pharmacy so that Mr C could collect his medication on a daily basis. Arrangements were also made with the pharmacist to monitor Mr C's compliance and to report to the care coordinator when either Mr C failed to collect his medication or if his mental health presentation was a cause for concern.

6.28 It was documented in Mr C's care plan that in order to mitigate the known risks, i.e. his ongoing risk of overdosing by stockpiling his medication and his non-compliance with his medication regime, the care coordinator would undertake weekly medication checks. However we noted that it was not documented how such monitoring was going to be undertaken, e.g. an actual physical search of Mr C's accommodation or a verbal confirmation by Mr C.

Risk assessments

6.29 Details from Southern Health's risk assessment (8 June 2012) were documented within the initial risk assessment undertaken by Solent's AOT. It outlined a brief summary of events from 2001, as well as assessments relating to Harm to Self, Harm from Others, Harm to Others and Factors Affecting Risks. The next risk assessment was undertaken during Mr C's admission to the inpatient unit on 30 January where in addition to the historical information it also documented the events that led up to the admission as well as providing on going updates following the various incidents that occurred during this admission. The following current and ongoing issues were identified as increasing Mr C's risk factors his "use of illicit substances, non-compliance with medication, perceived provocation from others, environmental factors including being in stressful situations and

[186] Interview with Solent Care Coordinator

being unable to see a way out. Protective factors include engaging with staff positively and accepting advice."[187]

6.30 Mr C's risk assessment was updated at each subsequent hospital admission; again documenting the reasons for the admission, identified the associated risk factors and updated the risk scoring. For example, Mr C was "at risk from others when is disinhibited or his behaviour is chaotic due to his mental state being unstable and he becomes involved with bullying behaviour."[188]

6.31 Brief risk assessments were also being undertaken prior to Mr C leaving the ward on leave and when he went AWOL. We noted that from 18 January 2013 progress notes were also being used to document particular incidents and their associated risk types.

6.32 During Mr C's first hospital admission following his transfer to Solent (January 2013), a forensic assessment was requested. Mr C met with a forensic psychologist on 6 February for an initial assessment but no further meetings took place.

6.33 The AOT also developed a Crisis, Relapse and Contingency Plan (dated 10 May 2013). This plan was completed by the care coordinator and identified that following indicators of Mr C becoming unwell: if "he talks of low self-worth, mood dips" and if he is presenting with "disjointed speech … Increasingly talks of being in the army … and has plans to harm others … he is to be considered for admission to hospital as his risks are too high to be able to be left in the community."[189]

Arising issues, comments and analysis

6.34 As we have already reported there were a number of issues relating to the handover of Mr C's notes from Southern Health to Solent services. Members of the AOT reported to us that they felt that they had not been given adequate time to set up the appropriate structures to support Mr C in the community and the inpatient unit reported that they had not been provided with adequate information regarding Mr C's extensive mental health history.

6.35 Based on the evidence that we reviewed, it appeared to us that from the point that the transfer occurred both the inpatient unit and the AOT were having to largely provide a reactive response to the various crises Mr C was presenting. Therefore, there was little opportunity for anyone to be able to undertake in-depth assessments of his risk and protective factors or to identify with Mr C his support needs. Decisions were being made based on the historical knowledge of individual clinicians and it was reported to us that the inpatient unit did not have the time to obtain Mr C's previous clinical notes or undertake a review of his historical contact with services. We would suggest that for a patient with such a complex and extensive medical history a review of his

[187] Risk assessment, 11 February

[188] Risk summary, 25 April

[189] Crisis, Relapse and Contingency Plan ,10 May 2013

notes should have been considered to be essential in order for informed assessments and judgements to be made.

6.36 We asked several inpatient clinicians to explain the various risk assessments that were undertaken and the rationale behind the decisions to discharge Mr C from the inpatient unit. It was explained to us that Mr C was considered a "challenging patient but not high risk."[190] Although, given his history of violence and carrying weapons, his long-term risks would always remain "significant"[191] (i.e. medium to high). But that when he was stabilised and compliant with his medication regime his acute psychotic symptoms reduced and his immediate risk would then be considered as low. At this point he would then be assessed as being fit for discharge.

6.37 We noted that the risk assessment form being used at the time did not categorise any level of risk assessment but merely identified issues as either "in the last six months or ever." We also noted that the narrative sections within Mr C's risk assessment did not always correlate with the risks that were identified within the risk grid.

6.38 There was also the same repeated narrative inserted in each assessment, which was cited to have been obtained from information that had been transferred from Southern Health's notes. Recent incidents were also being documented within the same narrative which we felt made the text of the assessment very dense and difficult to navigate the narrative in order to ascertain information regarding both recent events and risk factors and also to facilitate easy cross-referencing to the associated risks that were identified within the various grids.

6.39 In our review of the RiO notes, we found both risk assessments and details of risk incidents were also being documented within the progress notes. It was unclear to us exactly what the purpose and function was of documenting, in two different sets of notes, what was at times the same information. We would suggest that such duplication was time consuming and created a situation where important information could be potentially lost or overlooked. Additionally, at this time the inpatient unit's Ward Reviews and Care Planning Meetings were also documenting separately and by hand information, creating yet another location where significant information was being recorded. There was little evidence to indicate that decisions made at these meetings were being referenced within the records held on the RiO system. We found that all these different locations made it very difficult to access relevant information quickly and also to develop a comprehensive profile of Mr C's historic and current risk and support needs.

6.40 Another issue that we wish to comment on is the forensic assessment that some of the Solent clinicians, whom we interviewed, reported had been completed. The evidence indicates that the forensic psychologist did meet Mr C on 21 February 2013. But based on the brief notes that we obtained, it

[190] Interview with inpatient consultant psychiatrist

[191] Interview with inpatient consultant psychiatrist

appears that the purpose of this meeting was an initial assessment and that a further meeting was scheduled to take place on 21 February. Mr C did not attend this meeting, as he was admitted to hospital and that no further appointments took place in order for the forensic assessment to be completed. It was documented that the forensic psychologist did request that the inpatient unit inform her of Mr C's discharge in order for her to make arrangements to complete the assessment so that the findings could contribute to the decisions about the most appropriate living arrangements for Mr C. This did not occur and the only reference that we were able to locate regarding the forensic assessment was at a Ward Review and Care Planning Meeting (12 February 2013) where it was documented "forensic A- to continue on the 20:2:13."[192] It was not identified in any of the subsequent Ward Meetings (5 March and 9 April 2013).

6.41 As we have stated, all the inpatient and AOT staff whom we interviewed were adamant that a full forensic assessment had occurred and that the assessment was located within the RiO notes, but despite an extensive search we have only been able to obtain brief notes from the initial assessment meeting. This raised a number of concerns for us. Firstly, if, as the clinicians reported, they believed that a full forensic assessment had taken place we have to query why it had not been referred to in any subsequent documentation or risk assessments? Secondly given Mr C's known extensive risk history we would have thought that the clinicians would have been actively seeking information ascertained from the forensic assessment to underpin their own risk assessments and planning.

6.42 The lack of a forensic assessment being undertaken was also identified and discussed within the SIR. We were informed by both managers and individual practitioners that the findings from the SIR were cascaded down to all services as part of the Trust's learning process from serious incidents. Therefore, we were surprised that the clinicians continued to maintain to us that a forensic assessment had been completed.

6.43 With regard to the care plan pro forma, we noted that it does not indicate if a patient has agreed to the documented goals, nor if they were asked to sign or if they are offered a copy of the care plan.

6.44 We were informed that Solent is currently in the process of designing and implementing a new integrated patient records system (SystmOne). It was reported to us that the Trust is facing considerable challenges in both the design and the introduction of this new system. Apart from the technical and training challenges that developing and implementing a new system has created, it was also reported to us that there needed to be significant cultural changes for individual practitioners in order to create more user participation focus to risk and support planning; e.g., care plans and risk assessments should be written in the first person so that the voice and wishes of the service user are prominent. It is hoped that this will be achieved through a

[192] Ward Review and Care Planning Meeting, 12 February 2013

combination of the new bespoke integrated patient records system and the training and on-going supervision of individual practitioners.

6.45 The Trust's adult mental health services have introduced regular risk panels, where practitioners meet with senior medical staff to reflect on their more complex cases that have a large degree of risk. The aim being to encourage both a culture of reflective practices and a more shared approach to risk management.[193]

6.46 With regard to the care planning and identification of Mr C's support needs: we were unable to locate any documentation from one-to-one session notes within the RiO documentation from Mr C's various in-patient admissions. So we have to assume that these support sessions did not occur. It was reported to us that the main focus of the hospital admissions was to stabilise Mr C on various medications and to manage his behaviours on the ward. With regard to psychological and therapeutic support, it was reported to us that it was felt that Mr C's continued unsettled and chaotic behaviours, which were being exacerbated by his ongoing polysubstance misuse, made him an unsuitable candidate for more therapeutic interventions. We would, however, have expected that at the very least Mr C would have been receiving 1 to 1 support whilst he was an inpatient.

6.47 It was identified within Mr C's care plans when he moved to Solent that he was lacking the more practical skills required for independent living, such as cooking and shopping, and that he was experiencing considerable social isolation. There appeared to have been no consideration given to the possibility of applying for Personalised or Direct Payment Budgets[194] for Mr C. We would suggest that a Personalisation Budget could have funded additional support hours for Mr C and that such support would not only have enabled the provision of a more extensive programme of rehabilitation than statutory services were unable to offer, but would also have provided additional monitoring of Mr C's mental health and ongoing vulnerabilities.

Carers' assessment

6.48 It was clearly evident that from 1999, when Mr C first came to the attention of mental health services, Mr C's parents and other members of his family were very actively involved in supporting Mr C both when he was living in the community and during his numerous hospital admissions.

6.49 It was often documented that it was Mr C's parents who were alerting services when there was a decline in their son's mental health or reporting their concerns when they felt that he was being exploited by others.

6.50 Mr C's parents reported to us that they had felt that they had been regularly consulted and included in the care of their son both when he was a patient of

[193] Information supplied in interview with Quality and Standards Lead

[194] Personal and Direct Payments Budgets: allocation of funding given to users after a social services assessment of needs

Southern Health services and when he was at the medium secure unit. However they reported that they felt that they had not been consulted or included in their son's care and discharge planning during his Solent in-patient admissions, nor were they invited to any CPA meetings.

6.51 Mr C's parents also reported that they had not been consulted or notified when his son was going to be discharged from the Solent inpatient unit, although there were several occasions where it was documented that the care coordinator spoke to Mr C's father about his son being referred to more suitable accommodation.

6.52 We noted that there was no record during these admissions of Mr C requesting that his parents be excluded from his care. Indeed, judging from their extensive previous involvement and the many instances where Mr C had signed Consent to Share Information forms authorising that information could be shared with his parents, there was no reason to suppose that he would have objected to their involvement when he was transferred to Solent services.

6.53 Mr C's parents reported to us that they have never been offered a carers' assessment by either Southern Health or Solent services. This was confirmed in our review of the extensive documentation available to us from both areas.

Arising issues, comments and analysis

6.54 It was very concerning to us that there was no indication that either Southern Health or Solent services had offered Mr C's parents a carers' assessment. Such an assessment would have provided an opportunity for Mr C's parents to have had their emotional and practical support needs identified and a care plan to have been developed.

6.55 Both Trusts reported in their respective Carers' Strategies were fully committed to the National Carers Strategy[195] and NHS Commitment to Carers.[196] At the time of this incident Solent's Carers Strategy documented that "our services have a key role to play in identifying carers, providing them with timely helpful information and advice, as well as helping them to access support for themselves. Carers should be recognised and valued for the difficult job that they do, and feel supported to continue in their role if they are happy to do so."[197] Clearly, services should have offered a carers' assessment to Mr C's family, especially his parents, who were providing such extensive and enduring support to their son.

6.56 We also noted that the lack of a carers' assessment being undertaken was not identified within Solent's SIR, although one of its recommendations was to

[195] http://www.gov.uk/government/publications/the-national-carers-strategy

[196] www.england.nhs.uk/wp-content/uploads/2014/05/commitment-to-carers-may14.pdf

[197] Solent Carers Strategy 2012–2015

"ensure relatives and carers' views are considered and incorporated into treatment plans and care reviews."[198]

Recommendation 4: Solent NHS's Trust's revised risk assessment form should have separate sections for historical, current and ongoing risk factors. Each risk factor identified should be cross-referenced in the narrative section. Triggers and protective and contributory factors should be clearly identified for every area of risk.

Recommendation 5: Risk information should only be documented in one location within Solent NHS Trust's patient records system.

Recommendation 6: Consideration should be given during discharge and CPA planning to apply for Personalised Budgets or Direct Payments to fund additional care and support needs.

7 Drugs and alcohol

7.1 At the age of 17 (1996), after he was found guilty of burglary, Mr C was sent to a drug rehabilitation programme as part of his probation order however we were unable to locate any documentation from this programme. We did locate a letter from a consultant psychiatrist to Mr C's GP that reported that there was increasing concern at that time that Mr C's drug use was escalating and that there was an indication that he was now using IV heroin[199] and that this was seen as a significant factor in his mental health issues. However, a year later an inpatient consultant psychiatrist reported that "I was never convinced his problems were entirely due to drug misuse"[200] and that in his opinion Mr C was developing symptoms of a significant underlying mental health illness, e.g. schizophrenia.

7.2 Mr C was at this time repeatedly denying that he was using illegal drugs but it was also being documented that Mr C was socialising with known drug users. In May 1996 Mr C disclosed that he was using amphetamines and he was given the contact details of a drug support clinic. He was seen at this service (28 May), and it was noted that Mr C had reported that he had been regularly using 1–2 grams of amphetamines a week for at least the last year and had also been smoking cannabis. He was prescribed Fluoxetine[201] 20mg to support his withdrawal. Mr C failed to attend his next appointment at the clinic and was subsequently discharged from their case load. During his next psychiatric admission Mr C reported that his use of amphetamines had increased to 2–3 grams and that he was smoking cannabis and drinking on a daily basis.

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[198] Solent Clinical Review Report, August 2013, p38

[199] Letter from consultant psychiatrist to GP, 20 November 1996

[200] Letter from consultant psychiatrist to GP, 9 April 1997

[201] Fluoxetine: used to treat depression or obsessive–compulsive disorder in adults

7.3 Mr C is reported to have described[202] the period between 1996 and 1998 as being a time when he had felt that he was most settled as during this time he had been in a stable supportive relationship. However, towards the end of 1998[203] this relationship ended and Mr C was admitted to an inpatient unit with an acute psychotic episode. At the time of the admission he was disclosing that he had been taking heroin intravenously and that his alcohol intake had significantly increased.

7.4 From this point most of the clinicians who were undertaking metal health assessments of Mr C, were of the opinion that he was regularly abusing substances and regularly associating with known drug users.

7.5 By 2000 there was increasing evidence of a significant increase in Mr C's drug and alcohol use. It was being documented that he was disclosing that he had continued to use both cannabis and amphetamines regularly and that he was now also taking six to eight tablets of ecstasy a week. He also admitted that he had used crack cocaine "a few times"[204] and that on occasions he was using heroin intravenously. Although Mr C denied that he had issues with alcohol, he was reporting that generally he drank three cans of normal-strength lager and half a bottle of spirits a day, especially during more stressful periods, e.g. when his long-term relationship had ended. He reported that when he had tried to reduce his alcohol intake he had experienced significant withdrawal symptoms. In 2000 Mr C was admitted to a drug rehabilitation scheme, but following his self-discharge in 2001 it was documented that he recommenced his use of illegal drugs.

7.6 During Mr C's admission to the medium secure unit there were numerous documented occasions when it was being reported in Mental Health Tribunal Reviews that he was continuing to access and consume illegal drugs, e.g. cannabis and amphetamines, which he obtained either from other patients or whilst he was on leave. There was also more than one occasion when Mr C stole medication from the ward[205] e.g. in February 2007 he stole syringes and injected himself with Temazepam, and on another occasion he stole Lorazepam medication from another patient.

7.7 From the point that Mr C was discharged from the medium secure unit (2010) his drug and alcohol use was being repeatedly identified as a significant contributory risk factor in relation to his ongoing risks of harm to himself and others. In an admission on 20 January 2010, when Mr C was presenting with paranoid delusions he disclosed that he had injected heroin two days prior to admission. It was also being noted that his continued drug use was placing

[202] Letter from a consultant forensic psychiatrist to an inpatient psychiatrist, 20 September 2002

[203] 17 December 1998

[204] Letter from forensic consultant psychiatrist to community consultant psychiatrist, 30 November 2001

[205] February 2007

him at significant risk and vulnerability of harm and exploitation from other known drug users in the community.

7.8 Mr C's ongoing use of illegal and legal highs, as well as his misuse of his prescribed medications, especially benzodiazepines[206] such as Diazepam, was often noted as being a significant antecedent[207] to his repeated episodes of deterioration in his mental health.

7.9 From 2010 it was increasingly evident that there was a pattern of Mr C being admitted to psychiatric inpatient units, where there were modest improvements in his mental state. He was then discharged to the community services, where there was a rapid and dramatic relapse in both his mental health symptoms and associated risk behaviours, which was more often than not related to continued and escalating drug and alcohol use.

7.10 It was being noted within successive risk assessments that one of Mr C's significant contributory factors was his continued non-compliance with and abuse of prescribed medication, as well as his ongoing illegal drug use. By 2011[208] it was being documented that Mr C was now regularly consuming legal highs[209] and that they had now become a significant contributory factor.

7.11 At a ward review it was documented that Mr C agreed (12 February 2013) to engage with the drug and alcohol service. It was also documented[210] that Mr C was referred to this service but there is no further indication that this referral was progressed or that he was offered an appointment or assessment.

Arising issues, comments and analysis

7.12 It was well documented that from the age of 17 Mr C had a significant history of polysubstance use. It was very evident in our review of Mr C's chronology that his enrolment and rapid discharge from the army appeared to have coincided with his first recorded psychotic episode, where he was presenting with paranoid and persecutory delusions. From the evidence available it appeared that this was the period when his polysubstance abuse began.

7.13 There was no evidence that any agency considered the possibility that Mr C's repeated engagement in substance misuse may have been an attempt at him self-medicating in order to alleviate his distressing mental health symptoms that he was experiencing. At times Mr C appeared to have some insight into the detrimental effects of his illegal drug use on his mental state, whereas at

[206] Benzodiazepines are a class of psychoactive drugs used to treat anxiety, insomnia, and a range of other conditions

[207] An antecedent is a thing that comes before something else

[208] Letter from speciality doctor to GP, 4 March 2011

[209] Red Dove herbal high that can be bought online or in speciality shops on the high street

[210] CPA Episode Information

other times he reported that he believed that illicit drugs were more beneficial for his mental state than his prescribed medication.

7.14 Based on the evidence that we reviewed it was clear that Mr C's presentation and failure to respond to various medication regimes was often complicated by his persistent substance misuse. There were clearly some periods where Mr C had a fairly positive response to medication in terms of a reduction in his symptoms and that these were often associated with enforced periods of confinement, i.e. when he was in the medium secure inpatient unit, and therefore his access to illegal drugs was more limited. However, there is little doubt that when Mr C was afforded the opportunity, e.g. when living in the community, his propensity to use illicit substances and alcohol and latterly 'legal highs' were significant contributory factors in the deterioration in both his presenting mental health symptoms and his ongoing aggressive and antisocial behaviours. It was reported to us[211] that "were he not a substance abuser, particularly legal highs and stimulants, I think he would not have been that difficult to control but because he was intermittently using substances that were making the psychotic symptoms worse, the admissions were in the context of him taking substances and unsettled behaviours."[212] However, it was documented by another psychiatrist[213] that "of course it was impossible to be absolutely sure whether his substance use is of key importance aetiologically[214] in his illness or whether it is simply a maintaining factor and precipitating for relapses." [215]

7.15 Often Mr C was reporting that he had stopped taking illegal or legal highs as well as drinking alcohol but the evidence clearly indicates that this was not the case and that both remained a significant issue for him up until the incident in May 2013.

7.16 There was no documenting evidence to indicate if any clinician actually challenged Mr C's when he was reporting that he was abstaining from drug and alcohol use. From the documentation available it appears that they were consistently relying on Mr C's self-reporting, which, based on the evidence that we have obtained throughout this investigation, was often contradictory and unreliable.

7.17 When considering the management of Mr C's polysubstance use, we referred to the Department of Health Dual Diagnosis Practice Implementation Guide (2002).[216] This guidance suggests that with patients such as Mr C, who have both drug addiction and mental health issues, their "use of substances often exacerbates problems with their mental state, finances, legal issues and poor

[211] Interview with inpatient consultant psychiatrist

[212] Assessment by a consultant forensic psychiatrist, July 2010

[213] Assessment by a consultant forensic psychiatrist, 20 September 2011

[214] Cause or origin of a disease

[215] Assessment by a consultant forensic psychiatrist, 20 September 2011

[216] Department of Health Dual Diagnosis Practice Implementation Guide (2002)

engagement with services. Their needs are high and treatment outcomes are poor."[217] It goes on to suggest that "rather than seeing people with dual diagnosis as having two main problems, it may be more useful to acknowledge that they have complex needs … and often have difficulty accessing appropriate services due to their complex presentations."[218]

7.18 In Mr C's case it was evident that when he was given the opportunity to engage with specialised drug and alcohol services, such attempts failed. This was due to his ongoing ambivalence and lack of insight into the detrimental effects of his continued polysubstance misuse.

7.19 The above guidance also advocates that the care for such patients should be "mainstreamed and provided primarily by mental health services."[219] Their rationale is that mental health services are better placed to offer the intensity of input, such as crisis management, assertive outreach and more intense monitoring. This guidance, however, does not exclude a role for substance-misuse services and suggests that such services should continue to provide advice, support and, if appropriate, joint work to assist the mental health service in providing care for patients with a dual diagnosis. In Mr C's case, with his ongoing issues and ambivalence about engaging with services, it was highly unlikely that he would have actively sought to engage with another service. We would suggest that it may have been more successful if mental health services could have been in the position to provide treatment and support for his ongoing polysubstance misuse.

8 Housing

8.1 After Mr C left the army he initially went to live with his parents. However, by the time he was first admitted to a psychiatric inpatient unit (29 July 1993), he reported that for the previous few weeks he had been living rough and staying in various hotels, as he had not been getting on with his parents.[220]

8.2 A care plan completed on 19 January 1994 first identified that Mr C's housing situation needed to be addressed.

8.3 During Mr C's next hospital admission (October 1994)[221] it was documented that it was his parents' "expressed wish"[222] that their son did not return to the family home due to his disruptive behaviours. On his discharge from hospital, he initially went to live with a friend, reporting that it was his intention to live with his girlfriend. However, this relationship subsequently broke down. It is unclear where Mr C was then residing but by 1999 it was documented that he

[217] Closing the Gap, p4

[218] Department of Health Dual Diagnosis Practice Implementation Guide (2002)

[219] Department of Health Dual Diagnosis Practice Implementation Guide (2002)

[220] Letter from forensic consultant to consultant psychiatrist, 13 August 1993

[221] 29 August 1994 to 10 September 1994

[222] Letter from consultant psychiatrist to GP, 7 October 1994

was living in council accommodation. However, due to ongoing exploitation from Mr C's associates, who were using his accommodation for the purpose of drug trafficking and the consumption of illegal drugs, it was noted that he needed support to obtain more suitable accommodation that was nearer to his family home.

8.4 At a mental health assessment in 2002[223] (2 November) it was documented that prior to this admission Mr C was living alone and was still continuing to experience difficulties with regard to his association with the local drug community, who were "paying him regular and unwelcome visits and raiding his refrigerator."[224] He was quoted as reporting that he had purchased a knife to "prevent people from getting into my flat."[225] Such were the concerns about Mr C's ongoing safety that it was assessed that even with intensive support he was unable to continue to manage living in independent accommodation. The assessor went on to make several suggestions regarding alternative accommodation, such as local supported housing schemes that had links to the CMHT. However, it was noted that he would be unlikely to be accepted to any of these schemes if he continued with his drug use and aggressive and at times violent behaviours. The recommendation of this assessment was that he be detained under a section 3 of the Mental Health Act both to stabilise his mental health and to enable more appropriate accommodation to be sought. This admission continued through to 2004, during which time Mr C surrendered his tenancy and was then classified as No Fixed Abode (NFA). No further efforts were made to secure him suitable accommodation as he was then admitted to the medium secure unit until 2010.

8.5 As part of Mr C's discharge planning from the medium secure unit it was agreed at a CPA case conference[226] that Mr C would initially be moved into a less secure environment (i.e. a rehabilitation ward) at the unit. With the aim of ultimately discharging him into a community supported housing scheme. As part of this plan he visited a supported housing scheme, and he was reportedly[227] "very impressed and enthusiastic of transferring there."[228] On 9 July 2009 a section 117 meeting[229] was convened, as a placement at the scheme had been offered to Mr C. It was agreed that there should be a carefully managed transitional move-in process and the issues regarding

[223] 2 July 2002

[224] Letter to outpatient consultant psychiatrist, 30 November 2001

[225] Report to Mental Health Tribunal, 12 July 2002

[226] CPA Case Conference, 11 January 2008

[227] Psychiatric Report, 7 July 2009

[228] Psychiatric Report, 7 July 2009, p16

[229] Section 117 states that aftercare services must be provided to patients who have been detained in hospital: for treatment under section 3, under a hospital order pursuant to section 37 (with or without a restriction order) or following transfer from prison under section 47 or 48

which area was to be responsible for his care and the funding needed to be secured resolved prior to his move.

8.6 From the documentation available to us it appeared that the next meeting that was convened to discuss Mr C's discharge planning was six months later (2 January 2010). At this meeting it was reported that despite Mr C being accepted onto the scheme, it had taken nine months for the funding to be agreed due to the "funding application apparently (being) sent to the wrong place."[230] The placement was then no longer available due to the length of time it had taken to secure funding arrangements. It was documented that the supported housing had also raised concerns as to whether Mr C was suitable for the scheme. Another local supported housing project was then identified but it was reported that the waiting list for this service was between 6 and 18 months. It was agreed that it was far from ideal for Mr C to have to remain at the unit for this length of time, so he was then referred to another supported housing service. Mr C was subsequently accepted on this scheme but they also had a long waiting list (six months). The meeting agreed that until the placement became available Mr C should be moved onto the rehabilitation unit. Mr C finally moved out of the unit, initially on section 17 leave, on 22 November 2010. This was over 12 months after the initial care planning meeting which had identified that Mr C was ready to move into the community.

8.7 Soon after Mr C moved into the supported housing scheme the placement broke down[231] due to his increasingly aggressive and intimidating behaviour towards other tenants and staff. He was then admitted to hospital under a section 2 of the Mental Health Act (1983). During the course of this admission, it was documented that Mr C and his family were becoming increasingly frustrated about the lack of suitable accommodation being identified. Such was their frustration that Mr C's parents arranged for him to secure a private tenancy.

8.8 It was reported to us[232] that if supported housing had been secured for Mr C when he was discharged from the inpatient unit (December 2011), he would have received more intensive support (24 hours) and would eventually have been eligible to progress to less supportive move-on accommodation within the same scheme.

8.9 As we have previously identified elsewhere in this report the reasons why Mr C's parents eventually decided to move their son to the Solent area in 2012 was that it became increasingly evident to them that their son's association with other drug users was threatening both his mental health and his tenancy. There were also some reports that suggested that that Mr C had actually been given a Notice to Quit by his landlord for antisocial behaviour.

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[230] Minutes of CPA meeting, 29 January 2010

[231] March 2011

[232] Interview with Southern Health's care coordinator

8.10 During Mr C's last hospital admission (March 2013), there were ongoing discussions between Mr C's father and the care coordinator regarding the fact that Mr C appeared not to be managing living in the community and that despite efforts to relocate Mr C, it appeared that his old associates had become aware of where he had moved to and were visiting him. There were strong suspicions that drugs were again being taken at Mr C's accommodation.

8.11 A referral was made by the care coordinator via the Housing Panel's assessment and allocation system, to a dual diagnosis housing scheme. It was identified that the scheme would offer Mr C secure supported housing to support and stabilise him in the community.[233] After Mr C's discharge from hospital (5 March) he had initially expressed an interest in moving to this scheme but by 20 March it was noted that he was expressing increasing ambivalence. By 2 April he was at the top of the waiting list for this service and on 11 April it was documented that Mr C had agreed to end his tenancy on his flat. However, following a subsequent assessment by the scheme, [234] Mr C reported that he did not want to move to this type of scheme and that he wished to remain in his flat.

Arising issues, comments and analysis

8.12 During the course of our investigation, it was increasingly evident to us that as far back as 1993 the lack of suitable supported housing was a significant issue for Mr C.

8.13 There were also several unacceptable delays in securing Mr C appropriate supported accommodation when he was discharged from both the medium secure unit and the inpatient unit in 2012. This situation was noted at the medium secure unit to have caused considerable frustration for both Mr C and his family and also led to a significant delay in him being discharged from the unit. It was also identified as being a significant contributory factor in the decline of his mental health and behaviours on the ward.

8.14 Mr C's parents expressed to us their ongoing frustration that from the point where Mr C was discharged from the medium secure unit there had been both unacceptable delays and a universal lack of suitable supported housing being available for their son. On two occasions, in response to the delays in securing their son suitable accommodation, Mr C's parents reported that they felt that they had no alternative but to organised private rental properties for their son. Although it was reported that these properties were of good quality, he did not have access to the intensive levels of support that would have been available to him in either a mental health 24-hour-support service or as a tenant in a floating support housing scheme. Additionally, as these schemes were social housing they would have offered Mr C a more secure tenancy than can be found within the private rental sector.

[233] Presenting Situation &Referral Outcome Decision, 1 March 2013

[234] 17 April 2013

8.15 During our interview with the parents of the victim, Mr D, they reported that their son had found it difficult to secure affordable suitable accommodation. At the time of the incident he was living in a small privately rented accommodation. Both Mr D's parents and the Police Family Liaison Office (FLO) reported that this property was overcrowded and poorly maintained.

8.16 During the course of this investigation it was noticeable that there was a striking similarity between Mr C and Mr D with regard to their ongoing difficulties in obtaining appropriate, affordable and secure housing and that this left them both vulnerable in terms of their housing needs The correlation between inadequate housing, unstable tenancies, homelessness and mental health is well recognised. It is reported that people who are homeless have 40–50 times higher rates of mental health problems than the general population and that they are one of the most disadvantaged and excluded groups in our society.[235] Securing and maintaining appropriate housing is identified within the Department of Health's strategy 'No health without mental health'.[236] It concludes that inadequate housing and homelessness is a particular issue for people with mental ill-health. The strategy notes that "poor housing conditions and unstable tenancies can exacerbate mental health problems while periods of illness can in turn lead to tenancy breakdown."[237] Research[238] also indicates that individuals who have inadequate housing or experience homelessness often fail to receive the appropriate care and treatment for their mental health conditions for a number of reasons:

- "poor collaboration and gaps in provision between housing and health services;
- failure to join up health, social care and housing support services, and disagreements between agencies over financial and clinical responsibility; and
- Failure to recognise behavioural and conduct problems such as self-harm, self-neglect, tenancy issues such as substance misuse and anti-social behaviour."[239]

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[235] Department of Health. "No health without mental health: a cross-government mental health outcomes strategy for people of all ages". February 2011 https://www.gov.uk/government/publications/the-mental-health-strategy-for-england

[236] Department of Health. "No health without mental health: a cross-government mental health outcomes strategy for people of all ages". February 2011 https://www.gov.uk/government/publications/the-mental-health-strategy-for-england

[237] National Housing Federation http://www.housing.org.uk/policy/health-care-and-housing/mental-health

[238] St Mungo's, "Down and Out? Mental health and street homelessness", 2009

[239] St Mungo's, "Down and Out? Mental health and street homelessness", 2009

Recommendation 7: Risk assessments and support plans should always be identifying and considering a patient's housing situation. Where a patient is experiencing housing issues, this should be identified and considered as a significant risk factor and one that requires multi-agency intervention.

9 Contact with the criminal justice system

9.1 Mr C's first contact with the criminal justice system was reported[240] to be at the age of 17 when he and four of his friends were convicted burglary at a retail premises. Mr C received a fine.

9.2 The next contact Mr C had with the criminal justice system was on 6 February 1997, when he was 24, when he was charged with possession of an offensive weapon. It appears that Mr C was involved in an incident with a number of youths and that he took out the knife that he had been carrying. Mr C claimed that he had been acting in self-defence and to protect his sister and girlfriend. He also claimed[241] that at no time was it his intention to use the knife. It is unclear if this case went to court but based on the information in Mr C's forensic history that we obtained from the police it appears that he never received a custodial sentence for any of his historical offences so we can assume that either he was fined for this offence or the case was dismissed.

9.3 On 30 June 1999 Mr C received a police caution for possession of a class B drug (cannabis), which was discovered during the execution of a police warrant at his home address. Mr C claimed that the cannabis was for his own personal use.[242]

9.4 On 24 August 2003 Mr C was arrested for the possession of an offensive weapon. It was documented that Mr C had been seen leaving his accommodation "wielding a 7 inch kitchen knife."[243] He told the police that it had been his intention to kill his female neighbour. It was also documented that he had made similar threats over the previous months. Following his arrest Mr C was assessed and detained on a section 3[244] of the Mental Health Act (1983) and no criminal charges were brought.

9.5 During this hospital admission Mr C was charged and subsequently found guilty of causing criminal damage after he kicked and broke a large window

[240] Correspondence from Hospital to GP, 20 September 2002

[241] Information obtained from the police's Bad Character Report that was prepared for the Crown court hearing (2013)

[242] Information obtained from the police's Bad Character Report that was prepared for the Crown court hearing (2013)

[243] Information obtained from the police's Bad Character Report that was prepared for the Crown court hearing (2013)

[244] Under section 3 of the Mental Health Act (1983) a patient can be treated in a psychiatric unit for a period of up to six months. They can be treated against their will

on the unit. He was later given a conditional discharge and ordered to pay costs (17 February 2004). Mr C was arrested on two further occasions during this admission to this unit; on 2 May 2004 he was arrested following an assault on a fellow patient. This was documented to have been a premeditated act as Mr C had apparently asked the patient to remove his glasses before he had assaulted him. The victim sustained a fractured nose. At a subsequent magistrates' hearing Mr C was found guilty of ABH[245] and he was given a six-month section 37/41 Mental Health Act 1983 hospital order. Secondly, on 27 July 2004 Mr C allegedly bit a staff member on their hand. The CPS[246] made the decision "to (take) NFA[247] as not in the public interest to prosecute."[248]

9.6 Police records indicate that Mr C next came to their attention on the 21 January 2005, when he was a patient in the medium secure unit. It had been reported to them that during a dispute Mr C had kicked another patient. The victim refused to make a statement and it was decided that NFA would be taken. The following year (4 September 2006) it was alleged that Mr C had assaulted a male nurse by punching him in the face in what was described as an "unprovoked attack."[249] Again NFA was taken as it was documented that the nurse "did not want to go to court."[250] On 4 May 2007 Mr C was identified as having assaulted another patient, again, no charges were brought as the victim did not wish to make a complaint.

9.7 The next documented incident was on 17 January 2013, when Mr C was arrested and charged with section 4[251] and possession of an offensive weapon (knife). It was alleged that Mr C began to stalk a female worker at the pharmacy where he was collecting his medication. When her boyfriend confronted Mr C, he went home and allegedly he returned with a knife and threatened the couple. Armed police officers subsequently arrested Mr C at his home. At the time of the incident (May 2013) this case was pending. The only charge that Mr C was facing was that of possession of an offensive

[245] ABH: actual bodily harm

[246] CPS: Crown Prosecution Service

[247] NFA: no further action

[248] Information obtained from the police's Bad Character Report that was prepared for the Crown court hearing (2013)

[249] Information obtained from the police's Bad Character Report that was prepared for the Crown court hearing (2013)

[250] Information obtained from the police's Bad Character Report that was prepared for the Crown court hearing (2013)

[251] Section 4: this offence is referred to as threatening behaviour or intending to cause someone to fear or to provoke violence

weapon as the CPS had decided that the other charge would not be pursued.[252]

9.8 This case was to be heard at the Crown Court and that it was thought that there was a significant possibility that Mr C would have received a custodial sentence. The RiO notes indicate that the CJT and CC were discussing the possibility of recommending to the court that they should consider a Mental Health Treatment Requirement (MHTR).[253]

10 Post-incident Serious Incident Review (SIR)

10.1 As part of NHS England's Terms of Reference (TOR) for this investigation, we have been asked to "review the trust's internal investigation and assess the adequacy of its findings, recommendations and action plan."[254]

10.2 We benchmarked Solent NHS Trust's Level 2 Serious Incident Review (SIR) utilising the National Patient Safety Agency's RCA Investigation Evaluation Checklist.[255]

10.3 We undertook a telephone interview with the author of the SIR.

10.4 Following the incident Solent NHS Trust commissioned a "clinical review to investigate the care and treatment"[256] Mr C received from Solent NHS Trust's mental health services. A Level 2 internal investigation was undertaken with the purpose being to "ensure that any immediate safety issues were addressed and to learn lessons which may prevent the occurrence of similar incidents." The SIR was conducted by an independent investigator who was commissioned by the Trust.

10.5 As well as interviewing clinicians from both Southern Health and Solent mental health services the author of the SIR also interviewed Mr C in order to obtain his consent for them to discuss his care with his parents. It was deemed "inappropriate"[257] to continue with the interview with Mr C due to his mental health at the time.

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[252] Information obtained from the police's Bad Character Report

[253] Mental Health Treatment Requirements (MHTR) is one of three possible treatment requirements which may be made as part of a Community Order. The MHTR is intended for the sentencing of offenders convicted of an offence(s) which is below the threshold for a custodial sentence and who have a mental health problem which does not require secure inpatient treatment

[254] TOR Appendix B

[255] National Patient Safety Agency (2008), "RCA Investigation: Evaluation, checklist, tracking and learning log"

[256] SIR Category Level 2, August 2013, p3

[257] SIR, p8

10.6 Although the SIR author undertook a comprehensive review of the records from Solent's services, they did not gain access to the full records from Southern Health NHS Foundation Trust, the medium secure unit or the primary care service.

10.7 The SIR highlighted the following issues and concerns:

- "The transfer between the two Trust's community teams did not include CC or Consultant handover. Because of the lack of detailed history handed over; there was no review of past medication history, or record of chronology or details of previous offences or incidents. These would have informed risk and care planning.
- (Mr C's) parents were not invited to CPA reviews or ward rounds in Solent and (apart from CJT) no meaningful attempt was made to engage them. This was the parent's perception and is borne out by the investigation.
- The inpatient teams were largely non-compliant with the training requirements of Clinical Risk Assessment and Management Policy.
- No robust up to date training records were available in the inpatient area.
- There were omissions in records and documentation within the inpatient unit.
- Opportunities were missed to utilise the specialist skills and experience of the forensic psychologist whilst (Mr C) was an inpatient.
- The inpatient unit did not comply with policy guidance in relation to discharge planning and CPA at the point of the April discharge.
- There was no separate SOP or operational policy for the inpatient unit."[258]

10.8 The SIR report addressed each area of their TOF and its recommendations were SMART.[259] The author of the report also documented the changes that had been implemented within Solent since the incident and prior to their findings.

10.9 We concluded that the SIR provided a comprehensive chronology of and commentary on events from the point Mr C was transferred to Solent's community and inpatient services to the incident itself. An extensive review of both RiO notes and relevant policies that were operating at the time was also undertaken.

10.10 However, in our opinion there were several issues within the SIR that we would like to draw the Trust's attention to in order to improve future SI investigations. The author of the SIR interviewed Mr C's parents and noted

[258] SIR, p34/35

[259] SMART: specific, measurable, attainable, realistic and timely

their experiences and concerns. It also noted that they felt that they have been excluded from their son's care when he moved to Solent NHS Trust's community service and inpatient unit. However, the SIR failed to identify that Mr C's parents were not offered a carers' assessment by either Solent NHS Trust or Southern Health NHS Foundation Trusts' involved services.

10.11 Mr C's parents reported to us that although they had appreciated being involved in the SIR process they could not recall receiving any feedback from the findings of the SIR report. We were informed by Solent NHS Trust that they did meet Mr C's parents where they gave them a copy of the SIR report and also discussed its findings.

10.12 It was also not clear to us if the SIR utilised a clearly identifiable underpinning methodology. We would suggest that utilising a clearly established methodology, such as Root Cause Methodology would have assisted both the author and the reader to distinguish between causes and contributory factors.

10.13 We noted that the SIR did not include an Executive Summary as prescribed within the National Patient Safety Agency's RCA Investigation Evaluation Checklist. For future reference we would recommend that SIRs should clearly have an Executive Summary that includes the following: care and delivery issues, root causes, contributory factors and lessons learnt.

Recommendation 8: Serious Incident Review authors should always utilise and demonstrate within their report the underpinning investigative methodology that they are using, e.g. a Fishbone analysis of contributory factors

Recommendation 9: Serious Incident Review reports must fully comply with guidelines outlined in the National Patient Safety Agency's RCA Investigation Evaluation Checklist.

11 Solent NHS Trust and its progress in the implementation of the SIR's recommendations

11.1 Solent NHS Trust was founded on 1 April 2011. Currently it provides community and mental health services to people living in Portsmouth, Southampton and parts of Hampshire. There are 100 clinical sites throughout these areas which had, in 2014/15, 1.5 million patient contacts. There are currently 3,500 staff employed across all the services. The Trust's strategic objectives for 2012–17 are:

- "To provide services which enable improved health outcomes with particular focus on areas of known health inequality;
- To deliver care pathways that are integrated with local authorities, primary care and other providers; and

- To ensure sustainability of services through clinical and business excellence."[260]

11.2 In order to review and evaluate Solent's progress on the implementation of the SIR recommendations we interviewed their Quality and Standards Lead for Adult Mental Health Service, Chief Nurse, the Modern Matron and team leaders from the inpatient and AOT services. We also undertook a review of the relevant policies that were operating at the time as well as those that have been subsequently reviewed. It was also reported to us that since this incident the Trust has undergone significant changes in terms of both their service delivery but also within their governance structures.

11.3 With regard to the SIR's recommendations and the Trust's subsequent action plan, we noted that each recommendation had an associated action plan, with start and end dates, an action owner and an outcome/target identified.

11.4 Much of our discussions with the Quality and Standards Lead and Director of Nursing centred on the challenges that both practitioners and managers have been facing since this incident regarding information sharing with other Trusts when a patient is being transferred, identifying and supporting carers and the development and implementation of the Trust's new patient records system (SystmOne).

11.5 With regard to both the transfer of records and Solent services' management of the transition of care: Solent is currently in the process of procuring a new patient records system which has meant that the RiO to RiO functionality has been lost. As we have already identified this combined with the fact that the author of the SIR clearly identified deficits in the transfer of information and the management of the transitional phase from Southern Health NHS Foundation Trust to Solent's mental health services has resulted in the introduction of a Protocol for Receiving and Referring Transfers of Care between Solent NHS Trust and External NHS Organisations. This protocol identifies both the required referral process prior to transfer, including information sharing, and the management of the transitional phase itself to ensure that there is a planned transition and continuity of care. The protocol states:

> "CPA meetings with all relevant parties/stakeholders must be face to face with care co-ordinators from both the referring and receiving team being present. This is to take place within the first month from referral. A timescale for transfer over to the receiving care co-ordinator will be discussed and agreed at this meeting. The recording of the CPA review on RiO will be the responsibility of the referring team."[261]

11.6 Clearly the Trust is attempting to address the issues relating to the transfer of patients within this protocol but as we have already suggested that in order to

[260] http://www.solent.nhs.uk

[261] Protocol for Receiving and Referring Transfers of Care between Solent NHS Trust and External NHS Organisations

evaluate the effectiveness of this new protocol it would be helpful to undertake an audit of a number of cases where the protocol has been utilised

11.7 Carers' assessment and involvement: we saw ample evidence where the Trust has introduced policies and processes in relation to developing and embedding carers' initiatives. These include information packs, which are given to carers at the point of a patient's admission to an inpatient unit which explains their right to information and support. We would, however, suggest that this resource makes an assumption about the level of literacy of carers and it is unclear if it is readily available in other formats or languages.

11.8 There are also carers' forums on the inpatient unit, a carers' centre, an annual carers' conference. There are also a number of carers' representatives on the Trust's Residential and Community Operational Meetings.

11.9 These initiatives were evidence of the Trust's commitment to carers' involvement and support but we were mindful of that fact that during the course of our investigation, without exception all the practitioners who were interviewed reported to us that they were fully aware that Mr C's parents provided significant and enduring support to their son. But they were unable to explain why this had not triggered a carers' assessment. When we posed this question to one senior manager, it was suggested[262] that in their opinion there are several challenges and issues that create a "block"[263] for practitioners with regard to improving access for carers; such as the issue regarding confidentiality of information, especially when a patient has refused consent. It was suggested that this can lead to practitioners feeling that they should not speak to the carers in any circumstance. It was also reported to us that the Trust's training is currently trying to develop practitioners' awareness that "consent to share information is not just done at the once a year review, it is an ongoing, dynamic piece of work"[264] that should be addressed regularly with the patient.

11.10 It was also reported to us that the Trust is continually trying to address such issues and support a culture of change and inclusivity throughout its services and that this is currently being tackled at all levels of service provision. For example in late 2013 peer-review panels were introduced within mental health services. These are held on a monthly basis and the format is that different grades of staff are selected to come and talk about a particular case to the panel. This is to both ascertain if all the required assessments have been undertaken, e.g. Advanced Directives, risk assessment and support plans etc. but also to provide an opportunity for practitioners to reflect on their own practices with the Trust's senior managers.

11.11 In our discussions with various practitioners and the Trust's managers it was very evident that since this incident both inpatient and community services

[262] Interview with Quality and Standards Lead

[263] Interview with Quality and Standards Lead

[264] Interview with Quality and Standards Lead

have undergone a significant period of change. New care pathways, reporting and levels of accountability, as well as a universal recovery focus, now underpin all care plans and service delivery. The aim of the changes is to minimise hospital admissions, to provide consistency and continuity of care, to monitor compliance and improving to improve the standards of record keeping. It was evident that this has been a challenging time for all and as one senior Trust manager reported to us, it is still a "work in progress." [265]

Recommendation 10: In order to evaluate the effectiveness of Solent NHS Trust's Protocol for Receiving and Referring Transfers of Care an audit should be undertaken of a number of individual cases where this protocol has been utilised.

12 Predictability and preventability

12.1 Throughout the course of this investigation, we have remained mindful of one of the requirements of NHS England's Terms of Reference, which was that we needed to consider if the incident which resulted in the death of Mr D was either predictable or preventable. Whilst analysing the evidence we obtained, we have borne in mind the following definition of a homicide that is judged to have been predictable, which is one where "the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it."[266]

12.2 Clearly, a significant amount of information regarding Mr C's mental health history has only come to light during the course of this investigative process, as we were able to access the extensive clinical and social care notes from Mr C's admission to the medium secure unit, his primary care notes, and details from the police of their involvement with Mr C dating back to the 1990s. This information was unavailable to both the author of the SIR and clinicians from Solent's services. This benefit of hindsight[267] has been extremely useful to us as it has enabled us to develop a more comprehensive profile of Mr C's extensive mental health history as well as his continual risk of violence towards others and his own ongoing vulnerability to exploitation. It has also provided us with an awareness of the repeated issues and concerns that Mr C's parents were reporting about their son's wellbeing.

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[265] Interview with Quality and Standards Lead

[266] 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

[267] Hindsight bias is when actions that should have been taken in the time leading up to an incident seem obvious because all the facts become clear after the event. This leads to judgment and assumptions around the staff closest to the incident. Outcome bias is when the outcome of the incident influences the way it is analysed. For example, when an incident leads to a death, it is considered very differently from an incident that leads to no harm, even when the type of incident is exactly the same. When people are judged one way when the outcome is poor and another way when the outcome is good, accountability may become inconsistent and unfair. (NPSA 2008)

Predictability

12.3 During the course of our investigation we encountered repeated narratives that Mr C had a long and extensive history dating back to the 1990s of carrying weapons, knives in particular, and of repeated incidents of verbal and physical aggression, violence and frequent disinhibited behaviours towards others, especially during periods when he was acutely psychotic. From 2002 it was being assessed[268]that Mr C "had almost a reckless disregard for the safety of others, (and) a lack of empathy which rendered him a danger to himself as well as others."[269]

12.4 It was also extensively documented that Mr C repeatedly exhibited low tolerance to frustrations and that he persistently minimised the severity and effects of the incidents of violence and aggression, always citing provocation from others for his actions. Mr C would frequently use threats of violence towards others and self-harm as a coping strategy. It was also stated, in several assessments, that he lacked any motivation for change[270] and that he had unrealistic plans for his future. Mr C also consistently lacked any insight into his behaviours and his life choices and his continual polysubstance and alcohol misuse was frequently cited as a significant aetiology[271] and a contributory factor to his repeated mental health crises.

12.5 Throughout Mr C's extensive documented mental health history and in the events that led up to the incident it was well documented that Mr C persistently showed resistance to any therapeutic interventions and a poor response to the many different psychiatric medications that he was prescribed. Even during a period when Mr C was in the medium secure unit and his symptoms appeared, to some extent, to be responding to the medication although these periods were short-lived. There were repeated cycles when Mr C would be discharged from inpatient units in a relatively stable condition but rapidly he would become non-compliant with his medication regime, his polysubstance misuse increased and then his mental health significantly deteriorated, and he would be admitted to hospital. Mr C was also consistently either unwilling or unable to engage in any meaningful rehabilitation programme.

12.6 As far back as 2001 it was documented that Mr C was in possession of knives and it was reported, on several occasions, that "he couldn't give reassurance that others would be safe from him … and that he felt like stabbing people."[272]

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[268] Report to the Mental Health Review Tribunal, 8 July 2008

[269] Report to the Mental Health Review Tribunal, 8 July 2008, p1

[270] CPA Case Conference, 12 December 2008, p3

[271] Aetiology cause

[272] Letter from forensic consultant psychiatrist to community consultant psychiatrist, 30 November 2001

Another assessment concluded that based on Mr C's present and past behaviours he remained "at risk from others and is a risk to others."[273]

12.7 Bearing in mind the above indicator regarding the potential risks of violence and the numerous documented incidents where Mr C was exhibiting violence towards others, we concluded that, even based on the partial information that was known at the time by services, there was significant evidence to indicate that Mr C consistently had a combination of extremely high risk factors of violence and that he had very few protective factors. This ongoing and serious risk was not, in our opinion, adequately documented or considered within the risk assessments undertaken either before or after Mr C was transferred to Solent NHS Trust's mental health services.

12.8 We concluded that even based on the partial information that was known at the time of the incident, it was highly predictable that Mr C would be involved in another impulsive violent incident. Such an incident would either involve someone who was known to him or a stranger, as both had been previous victims of violent assaults by Mr C.

Preventability

12.9 In our consideration of the preventability of the incident, which resulted in the death of Mr D, we have asked ourselves the following questions. Was it reasonable to have expected agencies and individual clinicians to have taken more proactive steps, when he was transferred to Solent services, to obtain a comprehensive historical profile of Mr C? Also, if a more comprehensive profile had been obtained would it have significantly changed the various risk assessments and services that Mr C was provided with? Additionally, based on the information that was known at the time of the incident, was the decision to discharge Mr C following his final inpatient admission (April 2013) clinically safe and was the level of community support that was available to him adequate to manage his known risk factors? We have also asked ourselves did any one factor or a possible combination of all result in a failure to either adequately identify or assess Mr C's potential risks of violence towards others. Additionally if alternative interventions had been taken would they have prevent this incident itself from occurring?

12.10 As we have already reported the rationale behind the risk assessment and decision to discharge Mr C (April 2013) was that Mr C was considered a "challenging patient but not high risk" patient.[274] Although, given his history of violence and carrying weapons his long-term risks would always remain "significant"[275] (i.e. medium to high). However during periods when he was compliant with his medication regime his acute psychotic symptoms would significantly reduce and it would be assessed that his immediate risks were low. This was the situation at the time he was discharged from his last inpatient admission into the care of the community services (April 2013).

[273] Social Circumstances Report, 10 July 2002

[274] Interview with inpatient consultant psychiatrist

[275] Interview with inpatient consultant psychiatrist

12.11 There are a number of issues that we would like to highlight regarding the assessment and management of Mr C after he was transferred to Solent services: based on the evidence that we obtained it is evident that at no point did any clinician from the Solent services actively seek to obtain Mr C's past clinical notes. It is also evident that Mr C was an unreliable self-historian, especially with regard to his continued polysubstance misuse and non-compliance with prescribed medications. We concluded that both the lack of historical information and Mr C's unreliable disclosures resulted in his risk assessments and the decisions being made were being based on fragmented or partial information.

12.12 We concluded that it was extremely unfortunate that the forensic assessment did not take place during Mr C's last inpatient admission (April 2013). As this would have been the opportunity to obtain and review Mr C's forensic records from the medium secure unit thus enabling a more comprehensive assessment of Mr C's risk factors and a risk management plan to be developed by both Solent's inpatient unit and AOT service. For example the last risk assessment and management plan that was undertaken prior to Mr C being discharged from the medium secure unit (November 2010) noted that if he disengaged with mental health services, stopped taking his medication and returned to illegal drug use he should be admitted directly to a PICU, and that if he required longer-term treatment he should be transferred back to a medium secure unit. As this advice was not available it was not considered as being a possible course of action.

12.13 We have also concluded that there were all missed opportunities that would have enabled the identification that it was highly predictable that Mr C would be involved in another impulsive violent incident. However, at the time of the incident it had been assessed that although there were known risk factors Mr C was clinically fit for discharge and therefore he had the capacity to make the decision to live independently. Clearly based on Mr C's previous history this decision had significant risk factors that could be mitigated to a limited extend by the support offered by AOT. However apart from occasional visits by the AOT Mr C was mostly living unsupervised in the community. All that AOT practitioners were able to do was to schedule regular visits in order to support Mr C, to monitor both the known risks and signs of deterioration and to liaise with the pharmacist who was monitoring Mr C collection of medication and presentation. The care coordinator was therefore reliant on Mr C attending these meetings, his self-reporting and taking proactive measured when concerns were being expressed by Mr C's parent. However for the majority of the time Mr C was left to his own resources, which were clearly limited, and he remained vulnerable to both exploitation and to his high-risk lifestyle.

12.14 Additionally we also concluded that in our opinion, even if more informed risk assessments information had been available, given the fact that Mr C was living alone in the community with no restrictions, e.g. a Community Treatment Order, and limited supervision it is unlikely that the events of 11 May 2013 could have been prevented. We asked all the practitioners whom we interviewed if they thought that this incident could have been preventable. One clinician reported "I think preventable would have been the case if he had

engaged with taking medication, refrained from substances, engaged with the substance misuse services and engaged with the team fully, then it could have been prevented but it's difficult to say."[276]

12.15 Although we have concluded that the incident was not preventable we do suggest that if Mr C had been resident in a more supervised environment, such as an intensive supported housing scheme, he would have been closely supervised. In such a setting there might have been a greater opportunity for monitoring Mr C's mental health and polysubstance misuse and for identifying any escalating risks. His daily activities would have also been more closely monitored and there would have been greater regulations imposed with regards to visitors and alcohol consumption on the premises.

Overall analysis and recommendations

12.16 It was evident that Mr C suffered from a significant and treatment resistant major mental health illness combined with antisocial personality traits which resulted in him having significant and ongoing high risk factors and complex needs. From the point that he was discharged from the medium secure unit all his placements in the community failed. We would suggest that the repeated failure to secure Mr C suitable intensive supported accommodation and his failure to engage with services both contributed to his vulnerabilities, his significant and frequent mental health crises, and episodes of violence towards others. In our opinion he was not being as closely monitored and supported as he, in our opinion, clearly needed to be.

12.17 Finally, we would like to suggest that although the TOR asked us to look at the care provided by Solent NHS Trust we have identified some concerns and issues that are of relevance to Southern Health Foundation NHS Trust's mental health services with regard to the transfer of care of their complex and vulnerable patients to other Trusts. It is therefore our hope that our report and findings will also be shared with Southern Health NHS Foundation Trust.

Recommendation 11: NHS England should consider providing a copy of this report to Southern Health NHS Foundation Trust.

[276] Interview with consultant inpatient psychiatrist

13 Recommendations

Recommendation 1: For patients on Enhanced CPA when there has been a significant change in either their risk factors or medication, which have been made at their CPA review or during an inpatient admission, their care coordinator should discuss with the GP the future management of the patient.

Recommendation 2: Where there is a planned transfer of a patient between NHS Trusts the responsible clinician must ensure, wherever possible, that the transfer of medical records is completed before they accept responsibility for the patient's care.

Recommendation 3: A full review of a patient's historical medical notes must be undertaken by both inpatient and community services as part of their initial clinical and risk assessment.

Recommendation 4: Solent NHS's Trust's revised risk assessment form should have separate sections for historical, current and ongoing risk factors. Each risk factor identified should be cross-referenced in the narrative section. Triggers and protective and contributory factors should be clearly identified for every area of risk.

Recommendation 5: Risk information should only be documented in one location within Solent NHS Trust's patient records system.

Recommendation 6: Consideration should be given during discharge and CPA planning to apply for Personalised Budgets or Direct Payments to fund additional care and support needs.

Recommendation 7: Risk assessments and support plans should always be identifying and considering a patient's housing situation. Where a patient is experiencing housing issues, this should be identified and considered as a significant risk factor and one that requires multi-agency intervention.

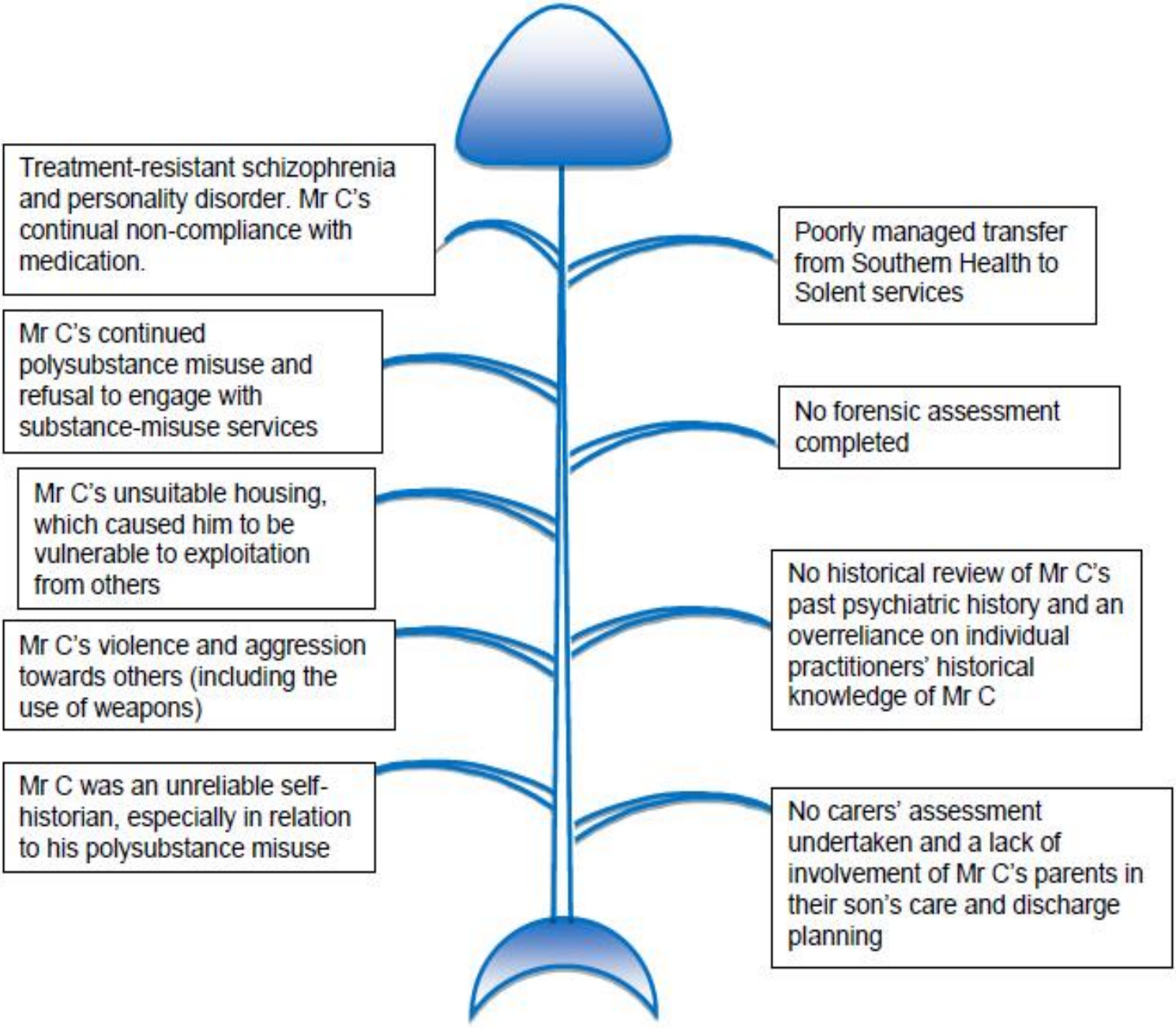
Recommendation 8: Serious Incident Review authors should always utilise and demonstrate within their report the underpinning investigative methodology that they are using, e.g. a Fishbone analysis of contributory factors.

Recommendation 9: Serious Incident Review reports must fully comply with guidelines outlined in the National Patient Safety Agency's RCA Investigation Evaluation Checklist.

Recommendation 10: In order to evaluate the effectiveness of Solent NHS Trust's Protocol for Receiving and Referring Transfers of Care an audit should be undertaken of a number of individual cases where this protocol has been utilised.

Recommendation 11: NHS England should consider providing a copy of this report to Southern Health NHS Foundation Trust.

14 Appendix A Fishbone diagram



15 Appendix B – Terms of reference

- To identify whether there were any aspects of the care Mr C received which could have been altered or prevented the incident from happening. The investigation process should also identify areas where improvements to services might be required, which could help prevent similar incidents from occurring.

- The overall aim is to identify common risks, best practice and opportunities to improve patient safety and make recommendations for individual, organisational and system learning.

Main objectives

- To establish if the risk assessment and risk management of Mr C was sufficient in relation to his needs, including the risk of Mr C harming himself or others
- To evaluate the mental health care and treatment Mr C received, including the adequacy of the risk assessment and risk management
- To identify key issues, lessons learnt, recommendations and actions by all those directly involved in providing the care plan
- To independently assess and provide assurance on the progress made on the delivery of action plans following the internal Trust investigation
- To identify lessons and recommendations that have wider implications so that they are disseminated to other services and agencies
- Identify care or service delivery issues, along with the factors that might have contributed to the incident
- Review the assessment, treatment and care that Mr C received from Solent NHS Trust up to the time of the incident
- Review the care planning and risk assessment policy and procedures and compliance with national standards
- Review the communication between agencies, services, friends and family, including the transfer of relevant information to inform risk assessment
- Review the documentation and recording of key information
- Review the communication, case management and care delivery
- Review the Trust's internal investigation and assess the adequacy of its findings, recommendations and action plan and identify:
    - If the internal investigation satisfied its own terms of reference
    - If all key issues and lessons have been identified and shared
    - Whether recommendations are appropriate and comprehensive and flow from the lessons learnt
    - Review progress made against the action plan and processes in place to embed any lessons learnt
- Review any communication and involvement with families of the victim and perpetrator before and after the incident

- Establish appropriate contacts and communications with families/carers to ensure appropriate engagement with the internal investigation process
- Review the relevant agencies from Mr C's first contact with services to the time of the offence. Consider if this incident was either predictable or preventable.

16 Appendix C – Chronology (key events from July 2012 to 11 May 2013)

Date	Source	Event	Comment
July 2012	RiO notes	Mr C moved from Southern Health to Solent area. Southern Health's Assertive Outreach Team (AOT) continued to support Mr C until 10 Jan 2013. They were visiting Mr C daily during the transition period.	
27 July 2012	RiO notes	Mr C was admitted to hospital having taking an overdose of tramadol (28) which he reported he had obtained from the emergency GP service. Discharged in care of Southern Health's AOT.	
4 October 2012	GP notes and interview	Registered with new GP	
19 October 2012	RiO notes	Mr C was admitted to hospital after he cut his neck with a piece of glass	
24 October 2012	GP notes and interview	First appointment with GP. Medication review completed. Noted that Mr C was being prescribed a high dose of Olanzapine.	
7 December 2012	GP notes and interview	Mr C presented at GP surgery with a laceration to his hand which was thought to have been caused by a knife	
9 January 2013	RiO notes	Mr C called an ambulance reporting that he had taken an overdose of LSD and amphetamines	
10 January 2013	RiO notes and care plan	Handover meeting between Southern Health and Solent AOT. Care coordinator (CC) from AOT present, but Southern' Health's AOT's CC was not present at meeting. A care plan was agreed and the following key issues were identified: Arrangements were made for daily collection of medication from pharmacy. Care plan noted that Mr C had an extensive history risk of potential harm to self or others.	.
15 January 2013	RiO notes	Prearranged visit by care coordinator (CC) and STR worker from AOT. Mr C not at home. Unable to make contact with Mr C.	
16 January 2013	RiO notes	Another failed visit to Mr C's accommodation by CC. Checked contact details with Southern Health and left a	

Date	Source	Event	Comment
		message on Mr C's mobile.	
17 January 2013	RiO and CJT notes and police records	CC contacted pharmacy who confirmed that Mr C had collected his medication on 16 January. Later that day pharmacist called CC reporting that Mr C had presented in a state of heightened anxiety and "had required paper bag to breathe." Mr C had reported to pharmacist that he had not been contacted by his CC. Mr C was arrested later in day for possession of an offensive weapon (knife) in a public place (S.4 Public Order). Mr C was arrested for allegedly stalking a female shop worker. When her boyfriend asked Mr C to leave her alone he returned with a knife. He then allegedly threatened the couple with it. He was subsequently arrested at his home. The arrest required armed police officers who negotiated with Mr C to surrender himself.	Court case pending at the time of the incident
18 January 2013	RiO and CJT notes	Seen by CJT team who arranged for him to be seen by nurse who dispensed medication. Mr C reported that he was hearing voices. CJT obtained Mr C's authorisation for them to contact his CC and AOT. Mr C was later released on bail with exclusion zone in place.	CJT: Criminal Justice Team CJT notes did not document what medication Mr C was given
21 January 2013	RiO notes	Mr C called CC to report that he was unable to collect his medication as the pharmacy was in his exclusion zone. Arrangements were made to have his medication delivered. CC informed Mr C's father of the plan. CC visited Mr C at his accommodation.	
22 January 2013	RiO notes	Mr C's father called CC to report that his son had breached his bail conditions (he had been in a taxi in exclusion zone). Mr C called AOT to inform them that the pharmacy was no longer able to deliver his medication and requested that CC deliver his medication. Later that day CC delivered his medication.	
23 January	RiO notes	Arrangements made by CC with another pharmacy (outside exclusion zone) re	

Date	Source	Event	Comment
2013		dispensing Mr C's medication. Visited by CC and STR worker. Mr C agreed to engage with community activities and also agreed to have a forensic assessment by a psychologist.	
25 January 2013	CJT notes	CJT worker phoned Mr C to say that she was unable to attend the scheduled appointment with Mr C. Documented that Mr C sounded "a little slurred" but that he reported that he was with his sister. He also confirmed that he had been receiving his medication.	CJT appeared unaware that Mr C had breached his bail conditions
28 January 2013	RiO notes	CC visited Mr C	
29 January 2013	RiO notes	STR worker visited Mr C. He declined to engage with any activities. Pharmacy called IET, reporting that Mr C was demanding that they deliver his medication. IET then contacted Mr C to advise him that his medication would not be delivered and that he had to collect it himself.	
30 January 2013	RiO notes	Mr C was admitted as an informal patient to the mental health unit after he was found near a naval base in full combat uniform. He was presenting in a psychotic state and it was thought that he had taken MDMA. Mr C later left the ward, informing staff that he was going home to collect a knife. Police informed. A subsequent search of Mr C on his return found no knife.	MDMA: ecstasy
5 February 2013	RiO and CJT notes	CJT liaised with ward. Ward staff reported that Mr C was fit to attend his bail hearing (8 February 2013), although this would be discussed at ward round.	
6 February 2013	RiO notes	Initial meeting with psychologist re forensic assessment	Next forensic assessment due 20 February 2013
8 February 2013	RiO and CJT notes	Bail hearing. Mr C was charged with two offences: possession of a bladed article and section 4 Public Order offence. He was bailed with conditions to attend Portsmouth Magistrates' Court on 22 February 2013. Exclusion zone to remain	

Date	Source	Event	Comment
		in situ.	
11 February 2013	RiO notes	Whilst on leave Mr C rang the unit to report that he was at A&E with alcohol poisoning. Ward agreed to arrange for a taxi to bring him back to the unit.	
14 February 2013	RiO notes	Assessed by drug and alcohol service re housing scheme.	
19 February 2013	RiO notes and interview with inpatient psychiatrist	Mr C was discharged from the unit with two days' medication. Diagnosed with a Dissocial Personality Disorder (code F602), mental and behavioural disorder due to multiple drug use and use of other psychoactive substances (F195), and paranoid schizophrenia (F200).	No CPA
21 February 2013	RiO notes and CJT notes	Mr C DNA his second forensic assessment. Mr C presented himself at a treatment centre with superficial cuts and saying that he had taken two days' worth of medication. Admitted for MH assessment and then informally admitted to unit.	DNA: did not attend. No further forensic assessment undertaken
22 February 2013	CJT notes	Mr C did not attend court hearing as was in hospital. Court case rescheduled for 8 March 2013.	
26 February 2013	RiO notes	CC and Mr C's father discussed possible referral to a dual diagnosis supported living scheme. CC agreed to look at the options as part of the discharge planning.	
28 February 2013	RiO notes	Following an uneventful leave from the ward, Mr C presented himself to ward staff (at 22:00) with cuts to both wrists. He initially refused to allow paramedics to attend but later agreed, and his wounds were sutured at A&E. He was admitted overnight to the assessment ward.	
1 March 2013	RiO notes	Mr C returned to the ward and threatened more self-harm. Mr C was searched by the police and a razor blade was discovered.	
2 March 2013	RiO notes	Mr C went AWOL. Police notified.	AWOL: absent without leave
3 March 2013	RiO notes	Mr C requested that he be discharged from the ward. Overnight leave granted until 5 March 2013. No medication available.	Unclear why there was no medication available
5 March 2013	RiO notes	Mr C discharged. Daily medication collections arranged with pharmacy.	No CPA

Date	Source	Event	Comment
6 March 2013	RiO notes	Referral made to dual diagnosis service	
7 March 2013	RiO notes	CC visited Mr C at his home	
8 March 2013	CJT notes	Mr C and his father attended magistrates' court. On the advice of his legal team Mr C did not enter any plea. Case adjourned until 9 April 2013 for a committal hearing. The magistrates' court indicted that the case would go to the Crown court. CJT worker noted that Mr C reported that he was collecting his medication daily from pharmacy since his discharge but that he had not taken any medication since the previous day. CJT worker asked to see what medication Mr C was currently prescribed. He presented a box with a dispense date of 7 March 2013 for Tramadol 50mg QDS. He also reported that he was given 200mg tablets Quetiapine but thought that he should only be taking 100mg tablets of Quetiapine. He also reported that he had not received any diazepam since his TTOs. Mr C's father reported that he was concerned that his son was being prescribed tramadol in light of his previous dependency. CJT worker phoned CC to report the confusion and Mr C's father's concerns re medication.	TTOs: take-home medication (to take out) from a hospital admission
12 March 2013	RiO and CJT notes	Seven-day post-discharge appointment with CC but Mr C was not at home. Mr C telephoned CJT to report that medication issue had been resolved. CJT spoke to Mr C's father who reported that he was concerned about weekend cover and was not convinced that his son was taking his medication. He also reported that his son was staying at his girlfriend's house and gave the CJT the address and telephone number. CJT passed these contact details to CC.	
14 March 2013	RiO notes	CC still unable to contact Mr C but spoke to his father who reported that he had seen his son that day. Further discussion between Mr C's father and CC re dual diagnosis supporting housing.	
15 March 2013	GP notes	Mr C attended surgery with his girlfriend, asking for additional prescription of diazepam. GP refused.	

Date	Source	Event	Comment
17 March 2013	RiO notes	Mr C contacted the unit, reporting that he was feeling as if he was going to self-harm.	Call transferred to CRHTT team
18 March 2013	RiO and CJT notes	CC made contact with Mr C who reported that he was feeling better after spending some time with his girlfriend. Agreed to see CC on 20 March 2013.Mr C's father then called CC and CJT, reporting that he was increasingly concerned re his son's increasingly chaotic behaviour. He reported that his son had given his house keys to a homeless man (the keys were later located and handed in to police on 20/03).	
20 March 2013	RiO notes	Mr C met with CC. Girlfriend present. Two members of IET present as per care plan and risk assessment. Noted that Mr C was ambivalent re supported living application. Agreed a further meeting on 27 March 2013.	
27 March 2013	RiO notes	CC tried to visit Mr C at his accommodation, but he was not there. CC tried to contact Mr C but he was not answering his phone.	
1 April 2013	CJT notes	Cluster assessment and Allocation form completed (including risk assessment).	
2 April 2013	RiO notes	Mr C was now at the top of the list for dual diagnosis supporting housing scheme.	
4 April 2013	RiO notes	CC still unable to make contact with Mr C. His girlfriend reported that their relationship had ended. Pharmacy reported that Mr C had not collected his medication since 26 March, and Mr C's father reported that he had not seen his son since 29 March 2013. 13:00 Mr C phoned CC, reporting that he was concerned for his son's state of mind and wanted him seen urgently. He was advised of the appropriate action if an emergency arose. 16:00 Mr C's mother reported that her son had fallen asleep at a family event and then left. 18:30 Mr C presented at A&E with psychotic symptoms, requesting admission to inpatient psychiatric unit. He was assessed and detained under sec 2 MHA to PICU. It was noted that Mr C had a wound on his right hand which had probably been sutured (17 sutures) within the previous three days. MH1 assessment	

Date	Source	Event	Comment
		completed.	
5 April 2013	RiO notes	Mr C's father visited the ward and expressed his concerns about the level of his son's self-neglect, his repeated admissions and his situation in living alone. Section 17 leave. Cluster assessment and HoNOS assessment completed. Letter to Mr C advising him of rights re Mental Health section 2.	HoNOS: assessment that measures health and social functioning of people with severe mental illness
7 April 2013	RiO notes	Mr C's father again expressed his concerns re his son's chaotic behaviours, e.g. his money management and giving his phone away to other people. He was advised by the ward staff that this would be discussed with Mr C and his CC with a view to working out what support he needed. Noted that Mr C was making inappropriate comments to female staff. When he was challenged that this was unacceptable behaviour he apologised. Another patient accused Mr C of kicking them, and threatening another patient who had said they witnessed it. The incident was not observed by any member of staff. The witness and Mr C then got into an argument and the ward staff had to intervene. Mr C was placed on 1:1 to safeguard him. Mr C reportedly told the nursing staff that he had a sword and had also hit and killed a patient at the medium secure unit (this did not occur).	
8 April 2013	RiO notes	Notes describe that Mr C was verbally aggressive towards staff in relation to his request for leave. Letter from inpatient consultant advising that Mr C was not able to appear in court due to his mental health.	
9 April 2013	RiO notes	Mr C was unable to attend court due to hospital admission. Case adjourned to 15 April 2013. Noted as presenting as hostile and thought disordered.	
10 April 2013	CJT and RiO notes	Solicitors advised that Mr C's case had been postponed until 15 April 2013. CJT requested report from inpatient psychiatrist regarding when Mr C may be well enough to attend court. RiO notes: Mr C was interacting well and	

Date	Source	Event	Comment
		was using his section 17 leave appropriately.	
11 April 2013	RiO notes	Mr C became argumentative with a female patient who accused him of taking pictures of her. She attempted to hit him, and he held her back. Noted that he was not aggressive but was attempting to defend himself without harming her. Discussed supported living option and Mr C agreed to end tenancy on his flat. 09:57: noted that Mr C fell into fellow patient. His elbow made contact with patient's nose, unclear if it was purposeful. Mr C denied intentionally hurting him but later stated the patient had threatened him when staff were not around.	
12 April 2013	CJT and RiO notes	Letter from inpatient consultant that Mr C was unfit to attend court hearing. Ongoing issues with same patient. Section 17 leave from ward.	
13 April 2013	RiO notes	13:00: Mr C was an hour late back from sec 17 leave, missing person policy implemented. He returned to ward intoxicated.	
14 April 2013	RiO notes	Female patient began shouting at Mr C; staff tried to intervene. The patient continued to antagonise Mr C and he hit her. Mr C was transferred to another ward.	Incident 108241
15 April 2013	RiO notes	20:00: noted that Mr C was invading staff's privacy, touching inappropriately and interrupting conversations.	
16 April 2013	RiO notes	Mr C returned to ward intoxicated; it was noted that he was "pushing boundaries with staff and a female patient."	
17 April 2013	RiO notes	Mr C was seen by the dual diagnosis supported housing scheme. He reported that he did not want a placement and that he wanted to maintain his own tenancy.	
18 April 2013	RiO notes	Mr C went AWOL. Returned later in evening.	
19 April 2013	CJT notes	Notified that the next court hearing was scheduled for 2 May 2015. Section 17 leave from ward.	Incident 108377
20 April 2013	RiO notes	Assaulted (kicked) a female staff member. Then went AWOL for four hours. Due to	Incident form completed

Date	Source	Event	Comment
		breach in Section 17 leave, Mr C informed leave suspended until next medical review.	(108339)
21 April 2013	RiO notes	Periods of verbal hostility towards staff. Mr C reported that he was experiencing auditory and visual hallucinations. 13:00: Mr C threatened to head-butt staff and was verbally aggressive and threatening. He then stamped on a member of staff's hand. Risk identified: abuse, aggressive and actual assault.	No incident form completed
23 April 2013	RiO notes	Discharged from section 2 at ward round. Mr C later threw a mug at a patient and continued to push the boundaries with ward staff.	
24 April 2013	RiO notes	Left ward without notifying staff. 01:25: Mr C swung a laptop charger around his head and attempted to hit male nurse. Risk assessment update to include notable increase in aggressive and assaultive incidents, in particular towards females. 14.37: when analgesia not immediately available, Mr C threatened to kill someone due to pain. Mr C then left ward; he did not wait for medication. He was discharged. RiO did not record time of discharge. Discharge summary sent to GP.	108448 AER form Doctor notes recorded increase in challenging behaviours, which were not related to Mr C's mental health. No CPA.
29 April 2013	RiO notes	CC attempted to visit Mr C at his accommodation. He was not there.	
30 April 2013	RiO notes	Pharmacy confirmed that Mr C had collected his medication	
1 May 2013	RiO and CJT notes	Seen by CC who notified CJT that Mr C was well and would be able to attend court hearing (2 May 2013). CJT informed that case was to be transferred to Crown Court.	
2 May 2013	CJT notes	Mr C and his father attended magistrates' court. Solicitors advised that the only charge was the offensive weapon as the CPS had dropped the other charge. The case was transferred to Crown court (31 May 2013); bail restrictions as before.	
3 May 2013	CJT and RiO notes	CJT contacted CC to discuss the possibility of a joint visit to Mr C to assess if mental health treatment order was required. Seen at home by CC: noted that Mr C appeared stable.	

Date	Source	Event	Comment
8 May 2013	RiO notes	Discussion re Mental Health Treatment Order at referral meeting	Mental Health Treatment Order imposed by courts: set of criteria e.g. drug tests, engagement with drug services, etc.
9 May 2013	Information supplied by Mr C's family	Mr C saw his mother and sister	
10 May 2013	RiO notes	Pharmacy reported to CC that Mr C was collecting his medication and appeared well	
11 May 2013	Police report	17:55 Mr C telephoned the police, reporting: "I've a dead person in my front room … he's taken about twenty or thirty stabs … to his neck, chest and back."	

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Solent NHS Trust:

Carers Strategy, (2015)

Clinical Risk Assessment and Management Policy and Procedure (20 March 2013)

CPA and Standard Care Policy (April 2013)

Inpatient Admissions, Transfer and Discharge Policy (2011)

Intensive Engagement Standard Operating Procedure

Protocol for Receiving and Referring Transfer of Care between Solent NHS Trust and External NHS Organisations (2014)

Psychiatric Observations and Engagement (April 2012)