An independent investigation into the care and treatment of a mental health service user (Mr S) in Somerset Partnership NHS Foundation Trust

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

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1 Executive summary

1.1 In March 2015 NHS England (South) commissioned Niche Patient Safety to conduct an independent investigation into the care and treatment of Mr S, to review the events that led up to the death of Ms G on 6 August 2013 and to consider whether the incident on 6 August 2013 was either predictable[1] or preventable.[2]

1.2 NHS England's Terms of Reference for this case also required us to assess the quality of Somerset Partnership NHS Foundation 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.

1.3 This case met the following criteria for the commissioning of an independent homicide investigation as set out in NHS England's Single Operating Model:[3]

'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'.[4]

1.4 This report was written with reference to the National Patient Safety Agency (NPSA) investigation guidance.

1.5 The incident occurred on 6 August 2013 in the accommodation of Ms G and her partner. Mr S, Ms G and her partner all originated from Sri Lanka. The exact nature of their relationship remains unclear.

1.6 On the day of the incident, CCTV footage showed that from 11:55am to approximately 2:30pm Mr S was in a local betting shop, where he reported to a friend that he had just lost his rent money in a slot machine. At 1:06pm Ms G's phone records indicated that she called Mr S. The call lasted 20 seconds; the reason for and contents of this call are unknown. Ms G's partner left the accommodation that he was sharing with Ms G at 4:30pm, and his last telephone contact with her was at 4:48pm.

1.7 Based on information provided by a neighbour, Mr S arrived at Ms G's accommodation between 5pm and 6pm. Between 5:10pm and 7:48pm, his mobile phone records indicated that he made13 calls. One call, at 6:57pm to a person in his contact list, lasted 46 minutes 13 seconds.

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[1] 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

[2] 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

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

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

1.8 At approximately 8:15pm two women arrived in the parking area. One of the women got out of the car and saw Ms G at the window, with her arms outstretched, shouting, “Help me.”[5] She reported that a male, who was subsequently identified by the police as Mr S, dragged Ms G away from the window. The police were called. Whilst waiting for the police to arrive, the woman looked through the window and saw Ms G lying on the floor with Mr S crouching over her. He was moving his right arm in what she described as mechanical up and down movements. Police arrived at the scene at 8:25pm. When they entered the flat they found Ms G on the floor with multiple stab wounds. Mr S had blood on his clothes, hands and face and was holding a knife.

1.9 The pathologist reported that the cause of death was stab wounds to the left-hand side of Ms G’s neck, which had severed her carotid artery and jugular vein; she had in the region of 50 to 100 other stab wounds.

1.10 The police reported that they were never able to establish the exact nature of the relationship between Mr S, Ms G and her partner, or the motive for the killing. However, the police reported that just prior to Mr S’s trial, they received an anonymous letter, written in English, from Sri Lanka. It accused Ms G and her partner of taking a considerable amount of money from Mr S’s grandmother, and the police concluded that if this was true, the motive may have been revenge.

1.11 On 4 March 2014 Mr S was found guilty of the murder of Ms G. He is currently serving a life tariff with a minimum term of 18 years in prison.

1.12 Mr S’s country of origin was Sri Lanka and he was from the Tamil community. Mr S was six years old when a 26-year civil war began in Sri Lanka. Mr S reported that in 1983, when he was five years old, his father was taken from the family home and not seen again. On 21 April 1985,[6] when he was eight years old, he witnessed his mother committing suicide by drinking bleach. From this point his extended family, mainly his maternal grandmother, brought him up.[7]

1.13 Mr S disclosed several slightly differing accounts as to the reasons surrounding him leaving Sri Lanka. During an inpatient detox assessment (12 March 2013), he reported that he had been involved in couriering, over army checkpoints, mobile phones and maps for his friends and that on the third occasion he was arrested by the Sri Lankan army. He reported that whilst he was imprisoned he had been tortured. It was repeatedly documented within Mr S’s medical notes that he had significant scars on his upper body that were thought to have been the result of this torture.

[5] Police summary of incident

[6] Date provided in the Border Agency’s report

[7] Information reported by inpatient consultant psychiatrist

1.14 On another occasion he reported that he had been arrested by the Sri Lankan army for being a member of the Tamil Tigers[8] and had been imprisoned for "two to three weeks."[9] Mr S also reported that he had bribed himself out of imprisonment and that an "uncle"[10] then arranged for him to enter the United Kingdom (UK). On another occasion Mr S reported that when he left Sri Lanka he undertook a journey across Europe and that on his arrival in the UK he applied for and was granted political asylum.[11] However, during the course of our investigation, we accessed information from the Border Agency which contradicts this account of his arrival in the UK. Records indicate that on 31 May 2004 Mr S applied for and was granted a three-week business visa to the UK and that he entered the UK in 2004.

1.15 Mr S next came to the attention of the Home Office on 21 May 2008, when it was identified that he had overstayed his visa. After several appeals he was granted leave to remain in the UK until 10 February 2016 with no restrictions.

1.16 During the course of this investigation, we undertook a review of the extensive research that is available regarding the profound psychosocial effects of this civil war on the Sri Lankan population

1.17 Research indicates that as a result of the trauma of this civil war, complex mental health and psychosocial problems often developed, resulting in dysfunctional behaviours and psychiatric disorders such as 'Post-Traumatic Stress Disorder (PTSD), depression, anxiety, somatoform disorders, alcohol and drug abuse'.[12] It was with these issues in mind that we have reviewed Mr S's mental health, his alcohol dependency, and his relationship with Ms G and her partner, as well as agencies' responses to his presentation and behaviours.

1.18 From the first point of contact with Scottish primary care services, it was Mr S's excessive alcohol consumption, rather than any particular mental health issue, that was identified by both Mr S and the GP as the main area of concern. The GP referred Mr S to an addiction treatment service. He was subsequently discharged from this service (8 September 2011), reporting that he had reduced his alcohol intake.

[8] Tamil Tigers: aka Liberation Tigers of Tamil Eelam (LTTE). Guerrilla organisation that sought to establish an independent Tamil state in northern and eastern Sri Lanka

[9] Primary care notes, 19 September 2008

[10] RiO notes, 12 March 2013

[11] In Sri Lanka the term uncle does not necessarily refer to a blood relative

[12] "A Critical Review of the Evolution of the Children's Play Activity Programmes Run by the Family Rehabilitation Centre (FRC) throughout Sri Lanka". Journal of Refugee Studies, 17, 1, 114–135

1.19 Mr S registered with a GP in Somerset in May 2012), where he disclosed that he was drinking 35 units a week.[13] On 15 September 2012 Mr S was arrested for drink-driving and failing to provide a specimen.

1.20 During the custody booking, a Custody Alcohol Test Assessment was completed where it was documented that Mr S was reporting that he wanted help with his drinking. The Alcohol Arrest Referral Worker saw Mr S and he was given an appointment to attend agency 1's[14] custody drop-in centre. During agency 1's assessment, Mr S reported that whilst he was living in Scotland he had made three suicide attempts and that he had started to drink when he was 22, but that his drinking only became a problem when he was 28.

1.21 On 28 January 2013 Mr S was admitted to A & E after he had taken an overdose of prescribed medication. It was assessed that based on Mr S's presenting symptoms, he was experiencing a 'mental and behavioural disorder due to use of alcohol.'[15] During this assessment Mr S disclosed that he was having difficulties with his flatmate and his girlfriend[16] who he said were 'always winding him up with constant insults and phone calls.'[17] He also accused them of burning and poisoning him. It was assessed that although it was difficult to formulate an accurate impression of Mr S's mental state, it was possible that there might be abuse from his flatmates, and due to the fact that he was presenting with a number of significant high risk factors, he was admitted to an inpatient unit for observation and further assessment for a possible psychotic illness. Mr S was discharged the following day and the Crisis Resolution and Home Treatment Team (CRHT) supported him until 10 February 2013.

1.22 On 14 February 2013 Mr S was taken to A & E as he had collapsed. He reported that he had drunk a bottle of whisky and some other alcoholic drinks. During his initial assessment it was documented that Mr S made some 'generalised comment about his life not being worth living.'[18] After staff obtained further information from the on-call CRHT, he was discharged.

1.23 On 27 February 2013 Mr S had an assessment with a doctor at agency 1. In the assessment letter, which was only sent to the GP, it noted that Mr S was 'deeply traumatised by the loss of both parents in childhood and other aspects of the conflict – pt himself was tortured by the Sri Lankan military. Has no social support network locally. Pt very vulnerable – has been swindled previously by 'friends'. Pt not really eating – spending any money he has on

[13] The Royal College of Physicians recommends that adult males should not drink more than 21 units a week http://patient.info/health/recommended-safe-limits-of-alcohol

[14] Agency 1 is an alcohol and drug service. Now after a retendering process it is a partnership between three services it is called Somerset Drug and Alcohol Service (SDAS)

[15] Progress notes 28 January 2013, 23:14

[16] Confirmed to be Ms G and her partner

[17] RiO notes, 29 January 2013, 9:33

[18] RiO notes, 20 February 2013

alcohol.'[19] The assessment concluded that 'Pt not suitable for community detox – will need in-patient detox with psychiatric input'[20] and that agency 1 intended to arrange an inpatient detox admission.

1.24 On 6 March 2013 Mr S was arrested by police and charged with being drunk and disorderly. As the custody sergeant had concerns about Mr S's mental health, he was referred to the Court Assessment and Advice Service (CAAS). During CAAS's assessment it was documented that Mr S had disclosed that he "would kill myself if I had a chance … that he was a waste of time and a nuisance to everyone … and that he prays to god every day to take me away."[21]

1.25 He also disclosed that he was hearing voices and experiencing hallucinations. Mr S was discharged, but later that day he was detained by the police on Section 136[22] after he was found lying on a railway line. Following a Mental Health Act (1983) assessment, Mr S was detained under Section2[23] and was admitted for an inpatient detoxification programme. He was discharged on 17 March 2013.

1.26 Police records indicate that they were called to an incident involving Mr S the day after he was discharged (18 March 2013) and that he was intoxicated. On 31 March 2013 Mr S was admitted to A & E following a suspected overdose of prescribed medication. Mr S's last contact with secondary care services was on 8 April 2013 when he was discharged from CAAS. From this point Mr S was only being monitored by his GP.

1.27 Police were called to an incident involving Mr S the day after he was discharged (18 March 2013) and that he was intoxicated. On 31 March 2013 Mr S was admitted to A & E following a suspected overdose of prescribed medication. Mr S's last contact with secondary care services was on 8 April 2013 when he was discharged from CAAS. From this point Mr S was only being monitored by his GP.

1.28 From January 2013 to the incident on 6 August 2013 Mr S had contact with Avon and Somerset Police on 25 separate occasions. Mr S was making numerous calls to the police, via 999, often on the same day. On most occasions Mr S was intoxicated, and at times he was abusive to the police call handlers and the attending officers.

1.29 There were also repeated instances when Mr S reported that he had been attacked or harassed or was being poisoned by Ms G and her partner. During this time Ms G's partner was also making repeated calls to the police,

[19] Letter to GP from agency 1 Speciality Doctor

[20] Letter to GP from agency 1 Speciality Doctor

[21] RiO notes, 7 March 2013

[22] *Section 136: The police can use an s136 of the Mental Health Act to take a person in a public place to a place of safety if they assess that a person has a mental illness and is in need of care. A place of safety can be a hospital or a police station. This section can be in place for up to 72 hours*

[23] Section 2, can be detained for up to 28 days for assessment and treatment

reporting that Mr S was either trying to gain access to their accommodation or was physically attacking him, and stalking both himself and Ms G at their place of work

1.30 There were several occasions when police officers managed the situation by utilising the restorative justice process[24] and they also completed several Anti-Social Behaviour (ASB) forms[25] classifying the incidents as 'nuisance'. The last police contact with Mr S was on 11 July 2013, when Ms G's partner contacted them to report that Mr S was trying to gain access to their accommodation. During the subsequent investigation of this incident, police deleted Ms G's partner's contact details from Mr S's mobile phone and advised him that any further incidences could lead to his arrest, which could affect his visa.

1.31 Mr S reported to the author of the Internal Serious Incident review (SIR)[26] that he had known both Ms G and her partner in Sri Lanka and that he had "treated the girl as a little sister."[27] However, Ms G's partner reported that they had only met Mr S when they came to England. Ms G's partner also reported that they had all initially lived together, but due to Mr S's ongoing drinking and behaviour, they had moved out. At the time of the incident they had decided to relocate to another area due to Mr S's ongoing harassment.

1.32 One of the significant issues that this case repeatedly highlighted was the systemic lack of information sharing between agencies about Mr S. We ascertained that apart from a joint agency protocol between Avon and Somerset Police Authority and Somerset Partnership NHS Foundation Trust, which specifically relates to Section 136 and Section 135[28] place-of-safety provisions; there was no protocol in place regarding information sharing between agencies. We have been informed that since this incident, a multi-agency Information Sharing Protocol[29] has been developed and implemented in Somerset. This protocol provides an overarching framework for the sharing of service users' personal information across health and social care sectors within Somerset. Both agency 1 and Somerset Partnership NHS Foundation Trust as well as the local police authority have adopted this protocol.

1.33 One of the areas identified within this protocol is related to the sharing of information for the purpose of risk management and the delivery of effective personal care, treatment and advice.[30] We concluded that clearly such a

[24] The restorative justice process requires that both parties meet and agree to the process. Requires an apology for the behaviour or actions or reparation of any loss or damage

[25] Anti-Social Behaviour (ASB) form records details of the event and allows for repeated problems with locations or an individual to be monitored for events

[26] Interview took place after Mr S's trial, 17 November 2014

[27] SIR interview, p2

[28] Section 135 enables police to obtain a warrant to search for and remove people where there is reasonable cause to suspect that a person believed to be suffering from mental disorder. http://www.legislation.gov.uk/ukpga/1983/20/section/135

[29] October 2014

[30] Somerset Information Sharing Protocol 2014, p11

protocol provides greater clarity with regard to information sharing. However, in this case, even if this protocol had been in place, it is unlikely that it would have altered the course of events, as Mr S was not being considered a high-risk patient and there was also no evidence to indicate that Ms G was at significant risk.

1.34 From Mr S's initial contact with secondary mental health and alcohol services, he disclosed not only his drinking but also that he was experiencing considerable financial difficulties and was imminently to become unemployed and homeless. The CRHT documentation noted that they had advised Mr S to attend both the housing department and benefits offices. There was no indication that any agency involved in his care provided him with information or supported him to access either Citizens Advice or other advocacy services that may have been able to provide culturally sensitive support. We would suggest that it was not realistic to have expected someone with such complex issues as Mr S was experiencing at the time, compounded by the fact that his first language was not English, to navigate the complexities of the housing and benefits system.

1.35 Apart from during Mr S's admissions to hospital, in January and March 2013, when it was recognised that Mr S's mother's suicide was an "actuarial indicator"[31] and he was thus considered, both acutely and in the longer term, to be "more at risk of ending his own life,"[32] his risk of suicide was assessed as low, and therefore no risk history was taken.

1.36 When we referred to Somerset Partnership NHS Foundation Trust's Clinical Assessment and Management of Risk of Harm to Self and Others Policy, we noted that it clearly directs that the suicide of a close family member should be considered a static and ongoing high risk. This is compatible with various research data that indicates that 'exposure to suicidal behaviour in peers and relatives is thought to increase risk for suicidal behaviour in vulnerable individuals … Offspring reporting exposure to suicidal behaviour were four times more likely to report a lifetime suicide attempt compared with unexposed offspring.'[33]

1.37 Based on such evidence and the clear directive within the Trust's policy, we would suggest that until such time as Mr S had undergone the appropriate psychological therapy and it had been assessed that he was no longer at significant risk of suicide, it should have been continually identified that Mr S was at acute and long-term significant risk of harm to himself. This would also have triggered a full risk history to have been taken each time a risk screen was completed and therefore would have consistently alerted practitioners to both Mr S's history and the fact that he was considered to be at high risk of suicide.

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[31] Actuarial indicator: risk according to probabilities based on statistical records

[32] Risk Information, 29 January 2013, 00.44

[33] *Effect of Exposure to Suicidal Behaviour on Suicide Attempt in a high-risk sample of Offspring of Depressed Parents* http: //www: //www.ncbi.nlm.nih.gov/pmc/articles/PMC2915586/

1.38 We noted that whilst Mr S was in A & E (January 2013), the admitting doctor and also a member of the CRHT documented that they had some difficulty understanding Mr S due to his level of sedation, his strong accent and the fact that he was often reverting to his native language. The Trust's Clinical Assessment and Management of Risk Policy (2012) states that "where the patient does not speak English, or does so as a second language, or has a sensory impairment, staff should consider requesting a suitable interpreter to be present when making the assessment."[34] We could find no documented evidence from any of Mr S's contact with primary and secondary health care services or agency 1 to indicate if they either considered the option of utilising interpreting services or asked Mr S if it would have been helpful to him for an interpreting service to be used.

1.39 We were concerned that despite Mr S's repeated disclosure to various agencies regarding the extent of his alcohol dependency, his weight loss, his poor diet and his visual presentation, for example 'baggy clothes',[35] this did not trigger any documented concern or assessment regarding the potential and significant physical health risks, such as malnutrition, of Mr S's lifestyle.

1.40 It was repeatedly documented within the Trust's RiO notes that the police were reporting that Mr S had a number of scars on his upper body that were the result of him being tortured by a welding torch in Sri Lanka.[36]

1.41 During our extensive review of all Mr S's primary and secondary notes, we were unable to locate any instance where there was visual sighting or documented details of his scars. When we asked staff why they had not asked to see or documented details of the scarring, they reported that they had felt that it was such an emotive issue for Mr S that they did not feel it was appropriate to discuss this issue with him or ask to see his scars. Although we do appreciate that this was a sensitive issue to address with Mr S, we do have concerns about this lack of visual examination and documentation by either primary or secondary practitioners. We would suggest that without accurate records of the marks on Mr S, or indeed any other patient, the patient and those providing the care are left in somewhat of a vulnerable position.

1.42 We would suggest that it is essential that when a patient is admitted to an inpatient unit, part of the initial assessment should include staff having sight of any scars etc. on a patient's body in order to assess if they are in need of treatment or to assess if there are signs of them being physically abused. For the safety and protection of both patients and staff, we would suggest that within RiO's Physical Health Examination pro forma, Somerset Partnership NHS Foundation Trust should consider introducing a body map. This would be utilised, with the patient's permission, to record all markings etc. Due to the

[34] Somerset Partnership NHS Foundation Trust, Clinical Assessment and Management of Risk of Harm to Self and Others Policy, August 2012, p5

[35] RiO notes entry, 8 March 2013

[36] Documented in discharge summary, 18 March 2013, as "believed were inflicted using a welding torch"

sensitivity of this issue Somerset Partnership NHS Trust should introduce clear guidelines for the assessing staff.

1.43 We noted that Somerset Partnership NHS Foundation Trust's Clinical Assessment and Management of Risk Policy, which was in situ at the time, made repeated references to the importance of involving patients in their risk assessments and care plans. It stated that 'all staff should ensure the outcome of the assessment and the resulting care plan is discussed with, explained to and given to the patient, and where appropriate their carer, in a language and format which they are easily able to understand.'[37]

1.44 There was no evidence that Mr S was involved in either his Risk Assessments or Recovery Support Plan. We also noted that the Trust's Risk Assessment format on RiO focuses on the professionals' assessment, and it is not evident how the patients, and where appropriate their carers, are involved in the process or if they are provided an opportunity to receive a copy of either their risk screen or recovery plan. The support that Mr S was offered from 29 January 2013 by all services was episodic and in response to crisis situations. There was no consistent long-term involvement of any agency, which led to a fragmented understanding of Mr S's presenting issues, his life experiences and their effects on his mental health and alcohol dependency.

1.45 All the agencies involved in supporting Mr S were documenting that they were aware that Mr S was suffering from PTSD as a result of his experiences in Sri Lanka, and the treatment plan was that he would be referred to specialist psychological therapy once he had achieved and was able to sustain abstinence from alcohol. This was in line with NICE's guidance with regard to treating and managing comorbidities, such as alcohol dependency, in PTSD.

1.46 The complex challenges that agencies were facing in engaging Mr S with both abstinence and a recovery programme are outlined within NICE's Post Traumatic Stress Disorder guidelines:

- 'Healthcare professionals should be aware that many PTSD sufferers are anxious about and can avoid engaging in treatment. Healthcare professionals should also recognise the challenges that this presents and respond appropriately, for example, by following up PTSD sufferers who miss scheduled appointments.

- For PTSD sufferers whose assessment identifies a high risk of suicide or harm to others, healthcare professionals should first concentrate on management of this risk

[37] Somerset Partnership NHS Foundation Trust, Clinical Assessment and Management of Risk of Harm to Self and Others Policy, August 2012, p5

- Healthcare professionals should pay particular attention to the identification of individuals with PTSD where the culture of the working or living environment is resistant to recognition of the psychological consequences of trauma'.[38]

1.47 NICE's guidance for drug treatment for patients with PTSD recommends that:

- 'Drug treatments (paroxetine or mirtazapine for general use and amitriptyline or phenelzine for initiation only by mental health specialists) for PTSD should be considered as an adjunct to psychological treatment in adults where there is significant comorbid depression or severe hyperarousal that significantly impacts on a sufferer's ability to benefit from psychological treatment.[39]

1.48 This was the drug regime that Mr S was prescribed. However, the following guidelines regarding the management of such a medication regime in patients such as Mr S were not followed by either his primary or secondary health care clinicians:

- Adult PTSD sufferers started on antidepressants who are considered to present an increased suicide risk and all patients aged between 18 and 29 years (because of the potential increased risk of suicidal thoughts associated with the use of antidepressants in this age group) should normally be seen after 1 week and frequently thereafter until the risk is no longer considered significant.

- Particularly in the initial stages of SSRI treatment, practitioners should actively seek out signs of akathisia, suicidal ideation, and increased anxiety and agitation. They should also advise PTSD sufferers of the risk of these symptoms in the early stages of treatment and advise them to seek help promptly if these are at all distressing.[40]

1.49 Apart from two clinicians who had direct personal knowledge of Sri Lanka and its complex political and social history, we found that although it was identified that Mr S had PTSD and that he had been a victim of torture, practitioners generally appeared to have only a slight knowledge of the context of Mr S's history.

1.50 NICE guidelines advise that: 'Where a PTSD sufferer has a different cultural or ethnic background from that of the healthcare professionals who are providing care, the healthcare professionals should familiarise themselves with the cultural background of the PTSD sufferer.[41]

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[38] NICE guidelines (CG26) March 2005, Post Traumatic Stress Disorder *http://pathways.nice.org.uk/pathways/post-traumatic-stressdisorder*

[39] NICE guidelines (CG26) March 2005, Post Traumatic Stress Disorder *http://pathways.nice.org.uk/pathways/post-traumatic-stressdisorder*

[40] NICE guidelines (CG26) March 2005, Post Traumatic Stress Disorder *http://pathways.nice.org.uk/pathways/post-traumatic-stressdisorder*

[41] NICE guidelines (CG26) March 2005, Post Traumatic Stress Disorder *http://pathways.nice.org.uk/pathways/post-traumatic-stressdisorder*

1.51 We found no evidence to indicate that practitioners had undertaken any research regarding the conflict in Sri Lanka and the particular issues that refugees may be facing from this type of violent conflict. Clearly we recognise that approaching such issues with a patient who is as vulnerable as Mr S was without doubt complex and must be undertaken with a great deal of sensitivity. But we did feel that without exception all agencies were primarily focused on crisis intervention and on Mr S's alcohol dependency and required abstinence rather than looking at these issues within a wider context.

1.52 There was also no indication that any practitioner was considering the possibility that Mr S's abstinence was likely to repeatedly fail until he was supported to at least begin to resolve the underlying root causes. Given this possibility, we would suggest that consideration should have been given to providing Mr S with specialist PTSD therapy despite the fact that his alcohol dependency continued to be an issue.

1.53 With regard to the inter-agency management of Mr S's care, the NICE guidelines clearly advise that:

- 'Where management is shared between primary and secondary care, there should be clear agreement among individual healthcare professionals about the responsibility for monitoring patients with PTSD. This agreement should be in writing (where appropriate, using the Care Programme Approach [CPA]) and should be shared with the patient and, where appropriate, their family and carers.

1.54 Patient preference should be an important determinant of the choice among effective treatments. PTSD sufferers should be given sufficient information about the nature of these treatments to make an informed choice.'[42]

1.55 We concluded that in the management of Mr S this type of inter-agency management plan did not occur, and, as we have already identified, his care was fragmented, there was little information sharing and there was no practitioner identified as the care coordinator.

1.56 We also concluded that both Somerset Partnership NHS Foundation Trust and the recommissioned Somerset Drug and Alcohol Service (SDAS) need to consider developing a specific policy for the provision of services, which includes both psychological and social needs, to refugees that includes NICE guidelines on managing patients with PTSD. The primary care service also need to familiarise themselves with NICE guidelines regarding the provision of care to this particular patient group.

1.57 From information that we have obtained, it is evident that after Mr S arrived in the UK, he moved both locations and accommodation on numerous occasions. On arrival in Scotland he was initially living in a refugee hostel, and it appears that on at least one occasion when he moved to the Somerset area his accommodation was provided by his employer. This meant that when he

[42] NICE guidelines (CG26) March 2005, Post Traumatic Stress Disorder *http://pathways.nice.org.uk/pathways/post-traumatic-stressdisorder*

lost his employment, he then lost his accommodation. He also appeared to live in several private rental properties, which meant that Mr S was facing high rents and insecure tenancies.

1.58 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.[43] Securing and maintaining appropriate housing is identified within the Department of Health's strategy 'No health without mental health'.[44] It concludes that inadequate housing and homelessness is a particular issue for people with mental ill-health.

1.59 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.'[45] Research[46] 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.'[47]

1.60 We benchmarked Somerset Partnership NHS Foundation Trust's Level 2 Serious Incident Review (SIR) utilising the National Patient Safety Agency's RCA Investigation Evaluation Checklist.[48] We concluded that the SIR provided a comprehensive chronology of and commentary on circumstances that led up to the incident and the various agencies' involvement.

1.61 However, 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. Although

[43] 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

[44] 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

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

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

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

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

the author concluded that the events that led to the death of Ms G were not predictable, the SIR failed to consider the preventability of the incident.

1.62 Additionally, although the SIR did identify that Mr S was a Sri Lankan national, it failed to consider his cultural needs or comment on whether the SIR author concluded that services were providing him with culturally sensitive support. Although it was alluded to, we felt that the SIR author did not adequately consider the possible psychological effects of Mr S's childhood experiences and the fact that he was a victim of torture and a refugee, or the possible connection between these experiences and Mr S's alcohol dependency. All of these issues we have concluded were significant in terms of his presentation and therefore were fundamental in the understanding of Mr S's relationship with services, his risk towards himself and others, and the events that led up to Ms G's death.

1.63 The author of the SIR referred to NICE guidance on Alcohol Use Disorder and Clinical Guidelines for Depression but did not make reference to NICE's Post-traumatic stress disorder (PTSD): The management of PTSD in adults and children in primary and secondary care (March 2005). We would suggest that it would have been helpful for the author of the SIR to have both understood and situated Mr S's PTSD and alcohol dependency within the context of the events in his personal history. It would also have enabled the author to evaluate the assessments that were undertaken and also the support being offered to Mr S by Somerset Partnership NHS Foundation Trust in light of NICE's guidelines.

1.64 The SIR's author concluded that as Somerset Partnership NHS Foundation Trust's services' last involvement with Mr S was on 8 April 2013, it was 'inappropriate'[49] to invite anyone from his social network or Ms G's family to be involved. We did not agree with this decision, as we felt that they might have been able to provide additional and valuable insight that would have helped to develop a more comprehensive profile of Mr S and of the events that led up to the incident itself.

1.65 The methodology utilised by the author of the SIR was Root Cause Analysis; however, we saw no evidence of this methodology within the report, for example a fishbone diagram.[50] Inclusion of such an investigative aid would have assisted the reader to focus on the causal factors.

Somerset Partnership NHS Foundation Trust and its progress in the implementation of the SIR's recommendations:

1.66 During the course of our investigation, we obtained two action plans relating to this case by the Trust. As the action plans were not dated, it was difficult for us to have a sense of their chronology, and also different report proformas were being utilised, so again it was difficult to cross-reference the actions

[49] SIR, p29

[50] A fishbone diagram is a visual way to look at cause and effect. Can help in brainstorming to identify possible causes of a problem and in sorting ideas into useful categories

taken and those that were still depending. However, based on their contents, it appears that action plan 1 was completed post SIR, and the second action plan was updated in January 2015, which was post Mr S's trial.

1.67 Action plan 1 directly relates to the four recommendations from the SIR report. It was only partially completed; for example the sections regarding evidence and 'how and to whom have the lessons learnt relating to the action been disseminated' were not completed and the actions identified were not SMART.[51] All the recommendations had update reports and three were reported to have been completed. The action relating to the clarification of the role of care coordinator in the CRHT and CAAS services identified that 'this will be taken forward through the Phase 2 integrated project.'[52]

1.68 It was reported to us that the aim of Phase 2 'is to make the patient pathway seamless both physical and mental health services would wrap around the patient as required … we are trying to build in an efficiency but also to improve the way in which services adjust to patients, so that the patient gets a better pathway through the service.'[53]

1.69 The second action plan has only one recommendation that is, 'to consider meeting the people named in the report with a view to understanding the situation and mental health services prior to the incident.'[54]The timescale for this was identified as "dependent on trial." There was a subsequent entry, dated January 2015, which notes that the "outcome of the trial in March 2014 was life sentence with a minimum of 18 years.

1.70 Due to the length of time from the incident and outcome of the trial the decision was made that 'a meeting would not be appropriate; however due Head of Division would be happy to meet with people named in the report if they request a meeting'.[55] We noted that there was no action documented regarding how and who was responsible for alerting the relevant people of this facility and also that this was not identified by either the SIR or the first action plan.

1.71 We noted that neither the SIR nor the subsequent action plans identified the need to offer feedback to either Ms G's family or her partner. We concluded that neither action plan was robust in relation to their contents, nor were there adequate processes in place for monitoring and evaluating implementation, and no post-impact analyses was undertaken to ascertain their impact.[56]

[51] SMART: Specific, Measurable, Achievable, Realistic and Time bound

[52] Action plan 1, p2

[53] Interview with Medical Director, Director of Governance and Corporate Development

[54] Local Action Plan, p1

[55] Local Action Plan, p1

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

1.72 It was also reported to us that it was unclear if Mr S's SIR and the subsequent action plan had been monitored by the SIRI group[57].The reasons given to us for the failure to monitor these action plans were unclear but we were reassured that the restructuring that has taken place since this incident, in relation to the monitoring of SIR action plans, were robust and that it was unlikely that this could occur again. However we would suggest that in order to ascertain the progress on the implementation of the Mr S's action plan Somerset Partnership NHS Foundation Trust should consider undertaking an audit exercise to ensure that all actions have now been fully implemented.

1.73 When we asked one senior manager what care pathways would now be available to a patient with similar risks and support needs as Mr S, it was reported that given his presentation and reluctance to engage with services, the care pathway available would probably not be different. However, it was reported to us that what have changed are the systems that are now in place to facilitate inter-agency information sharing.

Predictability and preventability:

1.74 Clearly, a significant amount of information regarding Mr S's historical and recent psychosocial background has only come to light during the course of this investigative process, as we have been able to access primary care notes as well as review Mr S's Border Agency file.

1.75 In addition we have had access to the Independent Police Complaints Commission's (IPCC) investigation report as well as some of their computerised records, none of which were available to either the primary and secondary health care services who were supporting Mr S or the author of the SIR report.

Predictability

1.76 Mr S's presentation to primary and secondary mental health and addiction services was often contradictory in terms of his risk to himself and others and his drinking. When he was sober, he would be polite and compliant although he was clearly ambivalent with regard to engaging with support and abstinence. However, when we reviewed the police records, it was evident that alcohol was a significant and contributory factor in all of the incidents where Mr S was either the victim or the perpetrator. It was also evident that whatever the cause, there were clearly ongoing conflicts and issues between Mr S and Ms G and her partner. However, at no time was there evidence of any physical violence by Mr S towards Ms G, most of the incidents involved relatively low-level anti-social behaviour and there was no evidence of any significant escalation in the period prior to 6 August 2013. Therefore, we have concluded that the incident on 6 August that led to Ms G's death was not predictable

Preventability

[57] SIRI Serious Incident Requiring Investigation Review Group

1.77 In our consideration of the preventability of this incident, we have asked ourselves the following two questions. Based on the information that was known, were Mr S's risk factors and support needs being adequately identified and assessed? Additionally, was it reasonable to have expected individual practitioners to have taken more proactive steps to have obtained information from either Mr S or others involved in services?

1.78 What was clearly apparent to us was that all services were operating and managing situations in isolation. Support was being provided to Mr S in response to the various crisis situations, and outside these situations no agency managed to engage Mr S in an ongoing relationship. Information was not being shared between the various agencies, including the police; therefore, services only had a fragmented knowledge and understanding of Mr S's issues. We concluded that no agency identified either the true extent of his ongoing risks to both himself and others, or the fact that he had no protective factors.

1.79 We have therefore concluded that based on what was known at the time, the incident itself was not preventable. Had a more inter-agency approach been adopted, then information could have been shared and a more comprehensive profile of Mr S's presenting issues and needs could have been identified. However, we would suggest that given Mr S's issues, relating to his PTSD, mental health and alcohol dependency issues, it is likely that he would have continued to be a very vulnerable and unpredictable individual who until such time as he was able to resolve these complex issues would have remained at significant risk to both himself and others.

Concluding comments:

1.80 During the course of our investigation, it became very evident that Mr S was experiencing many complex issues with regard to his mental health, alcohol dependency and the effects of his traumatic personal history. These issues were also being compounded by his lack of secure employment and housing, social isolation and the psychosocial issues of being a refugee in the UK. There was clearly multi-agency involvement with Mr S, but they were mainly providing a reactive service to Mr S and operating in their respective service silo. This resulted in information regarding his potential risk both to himself and others not being shared, fragmented support being provided to Mr S, and a failure to engage him in any long-term treatment plan.

1.81 Although it was recognised that Mr S required specialist psychological intervention for his PTSD, this was a long-term plan that required him to be abstinent from alcohol before it began. We concluded that given Mr S's multiple complex issues, it was difficult to see how he could have achieved this without considerably more intensive and appropriate support being available. With regard to Mr S's cultural needs, we found no evidence to indicate that any agency was paying particular attention to his cultural needs or considering what understanding Mr S may or may not have had in relation to his mental health needs and the services that were being offered to him.

1.82 Finally, we concluded that although there were incidents where Mr S was perceived to be the perpetrator of violence and public order offences, he was in fact a very vulnerable adult whose chaotic lifestyle was contributing to both his vulnerability and risks to himself and others. Although the incident itself was not predictable, it was evident that at the time of the incident, Mr S had no protective factors. Therefore, we would suggest that what was predictable was that whilst services continued to primarily focus on abstinence, there would have been a continued deterioration in Mr S's mental health and increased risks to both himself and others.

Recommendation 1

Somerset Partnership NHS Foundation Trust:

Recommendation 1: When assessing and providing support to patients whose first language is not English, primary and secondary care services must always consider the option of utilising an interpreting service.

Recommendation 2

Somerset Partnership NHS Foundation Trust:

Where it is known that a patient is experiencing financial or housing issues secondary mental health services should be identifying, as part of the patient's care planning, details of the relevant advocacy and support services and supporting them in accessing such services.

Recommendation 3

Somerset Partnership NHS Foundation Trust:

Where static long-term and acute risk factors have been identified as being significant, they must continue to be assessed and documented at this level until such time as it can be evidenced that there has been a significant change in a patient or that there are new robust protective factors in place.

Recommendation 4

Somerset Partnership NHS Foundation Trust:

For the safety and protection of both patients and staff, RiO's Physical Health Examination pro forma should include a body map that is used, with the patient's permission, to record any injuries, scars, bruises etc. on a patient's body. Somerset Partnership NHS Foundation Trust should introduce the appropriate guidelines regarding the use of body maps.

Recommendation 5

Somerset Partnership NHS Foundation Trust and Somerset Drug and Alcohol Service:

Both Somerset Partnership NHS Foundation Trust and the recommissioned Somerset Drug and Alcohol Service (SDAS) need to consider developing a specific policy, which includes consideration of the psychological, accommodation and social needs in the provision of services to refugees. Such a policy should include NICE's guidelines on supporting such patients with PTSD.

Recommendation 6

Primary Care Service:

Recommendation 6: The primary care service involved in this case should familiarise themselves with NICE guidelines regarding the provision of health care to refugee patients.

Recommendation 7

Somerset Partnership NHS Foundation Trust:

The Trust's Risk Assessments and Recovery Care Plans should have a section to indicate if a patient has been involved in the process. The form should also indicate if a patient has agreed with the assessment and if not it should be documented what are their reasons. Also the assessment and plan should indicate if the patient has been asked if they would like a copy.

Recommendation 8

Somerset Partnership NHS Foundation Trust:

Risk Assessments and Recovery Support plans should always identify and consider 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 and support.

Recommendation 9:

Somerset Partnership NHS Foundation Trust and Somerset Drug and Alcohol Service:

Somerset Drug and Alcohol Service (SDAS) and Somerset Partnership NHS Foundation Trust must agree a formal information-sharing protocol.

Recommendation 10

Somerset Partnership NHS Foundation Trust:

Authors of Serious Incident Reports must include evidence within their reports of the methodology that is being utilised within their investigations, for example Root Cause Analysis, a fishbone diagram, 5 Whys.

Recommendation 11

Somerset Partnership NHS Foundation Trust:

Authors of Serious Incident Reports must ensure that they are referring to all the relevant NICE guidelines that were in place at the time of the incident.

Recommendation 12:

Somerset Partnership NHS Foundation Trust:

The Trust's Safeguarding Adults at Risk Policy should direct practitioners to consider a patient's culture and ethnicity as being significant and interconnecting factors to both their vulnerabilities and their potential risks of being abused.

Recommendation 13

Somerset Partnership NHS Foundation Trust:

The Trust should adopt a universal action plan proforma and ensure that the relevant STEIS incident number is clearly documented on the original and on subsequent action plans.

Recommendation 14

Somerset Partnership NHS Foundation Trust:

In order to ensure that all the action plans that have arisen out of this Serious Incident Report have been fully implemented, the Trust should undertake an immediate audit of each recommendation.

Recommendation 15

Somerset Partnership NHS Foundation Trust:

In order to evaluate the effectiveness of the new information-sharing systems introduced since this incident, the Trust should consider undertaking an audit exercise of a number of cases, involving similar complex patients, where there is both internal and external multi-agency involvement.

Niche Patient Safety's condolences to the family of Ms G:

Niche Patient Safety investigation team would like to offer their deepest sympathies to the family and partner of Ms G. It is our sincere wish that this report does not contribute further to their pain and distress.

Acknowledgement of participants:

Niche Patient Safety investigation team would like to acknowledge the contribution and support that staff from Somerset Partnership NHS Foundation Trust, Avon and Somerset and Wiltshire Police Authorities have provided throughout the course of this investigation.

2 Offence

2.1 The incident occurred on 6 August 2013 in the accommodation of Ms G and her partner.

2.2 Mr S, Ms G and her partner all originated from Sri Lanka. The exact nature of their relationship remains unclear and is discussed further in section 7 of this report.

2.3 CCTV indicated that at 11:55am Mr S entered a betting shop in the town centre where he placed a bet. A witness reported that he had a 10- to 15-minute conversation with Mr S. He recalled that Mr S had reported that he was unhappy, as the Job Centre was only offering him part-time work, and that he wanted to move to London or Liverpool in the near future. The witness then offered to lend Mr S some money, but he declined.

2.4 At 1:06pm Ms G's phone records indicated that she called Mr S. The call lasted 20 seconds. The reason for or contents of this call are unknown.

2.5 At 2pm another witness saw Mr S at the same betting shop playing on the gambling machines. Mr S reported that he had just lost £70 in the slot machines and that this was his rent money. The witness recalled that Mr S was clearly upset about losing the money but that he did not appear to be drunk. At approximately 2:30pm Mr S left the betting shop without saying goodbye to anyone, which, it was reported in a witness's police statement, was unusual behaviour for him.

2.6 At 3:30pm Ms G's partner arrived home and he reported that he discussed with Ms G their impending move to another area so that Ms G could find employment. He then remained at the property until 4:30pm at which point he left, as he was due to start work at 5pm. Ms G asked him to call her when he arrived at work.

2.7 On his journey to work, Ms G's partner missed two calls (at 4:43pm and 4:45pm) from Ms G. When he arrived at work he called Ms G (at 4:48pm). During this call, Ms G reported that her parents were calling her and that it was her intention to call them after they had finished talking. This was the last contact that Ms G and her partner had.

2.8 Mobile phone records indicate that the last activity on Ms G's mobile phone was at 4:57pm when she texted a contact in her phone address book. The text stated 'cash received thanks.'[58] During the course of their investigations, the police were unable to ascertain the recipient of this call.

2.9 A neighbour reported that between 5pm and 6pm they heard the letter box to Ms G's flat rattle. This was a noise that they often heard, and they assumed that Ms G had let someone into her flat. They then overheard a male voice

[58] Police summary of incident

from inside Ms G's flat and stated that the tone of this voice was not aggressive. The police have assumed that this was Mr S entering Ms G's flat.

2.10 Between 5:10pm and 7:48 pm, when police have assumed that Mr S was in Ms G's flat, his mobile phone records indicate that he made 13 calls. One call, at 6:57pm, lasted 46 minutes 13 seconds to a person in Mr S's contact list. This person's surname indicated that he may have been of BME heritage,[59] but during the course of their investigations the police were unable to establish contact with this individual.

2.11 At approximately 7:45pm to 7:50pm a neighbour reported that she had returned to the building and had not seen or heard anything unusual in or near Ms G's flat.

2.12 Between 8pm and 8:10pm another neighbour heard increasing raised voices and banging noises coming from Ms G's flat.

2.13 At approximately 8:15pm two women arrived in the parking area, and whilst they were sitting in the car the driver became aware of a man looking out of one of Ms G's windows. One of the women then got out of the car and saw Ms G at the window with her arms outstretched, shouting, 'Help me.'[60] She reported that a male, who was subsequently identified by the police as Mr S, dragged Ms G away from the window, and she shouted to her friend in the car to call the police.

2.14 Whilst waiting for the police to arrive, she continued to look through the window and saw Ms G lying on the floor with Mr S crouching over her and moving his right arm in what she described as mechanical up and down movements. Another witness arrived and on looking through the window also saw the incident occurring. Neither witness was able to identify what was in Mr S's hand.

2.15 At 8:24pm two police call handlers received calls from Mr S's mobile stating that they needed to come to the address of Ms G as "I have just done a murder."[61]

2.16 Police arrived at the scene at 8:25pm; they initially tried to gain access to Ms G's flat by the front door, but it was locked. After two unsuccessful attempts to force the front door, they gained entry to Ms G's flat via a window. The arresting police officer's report indicates that Mr S had blood on his clothes, hands and face.

2.17 The arresting officers were wearing body cameras which recorded that during his arrest Mr S said the following: "if she dies she cannot cheat my granny … I

[59] BME: Black and minority ethnic

[60] Police summary of incident

[61] Police summary of incident

hope she is dead she's not eligible to be in this world … How many years for this 10, 20, 30 years."[62]

2.18 The pathologist reported that the cause of death was stab wounds to the left-hand side of Ms G's neck which had severed her carotid artery and jugular vein. It was also reported by the pathologist that it was not possible to identify the exact number of stab wounds, but it was thought to have been in the region of 50 to 100. Ms G had three defensive wounds on her hands.[63]

2.19 Ms G was 32 years old when she died; she had a 7 year old daughter who was living with her grandparents in Sri Lanka. She was in regular phone contact with her family in Sri Lanka.

2.20 Until April/May 2013 Ms G had been working at a local discount store, but it was reported[64] that she had resigned due to "harassment"[65] at her place of work by Mr S.

2.21 The police reported to us that they were never able to establish the exact nature of the relationship between Mr S, Ms G and her partner or the motive for the killing, as during Mr S's police interviews and at his subsequent trial he did not disclose his motive for the killing of Ms G. However, just prior to Mr S's trial, the police reported that they had received an anonymous letter, written in English, from Sri Lanka. It accused Ms G and her partner of taking a considerable amount of money from Mr S's grandmother, and the police concluded that if this was true then Mr S's motive may have been revenge. The letter also appeared to indicate that Ms G, her partner and Mr S all came from the same village in Sri Lanka. This was vehemently denied by Ms G's partner during his police interview.

2.22 It was not documented in any reports that we had access to whether police carried out an alcohol blood test when Mr S was arrested to ascertain his alcohol levels. Therefore, we are unable to conclude if alcohol was a contributory factor.

2.23 On 4 March 2014 Mr S was found guilty of the murder of Ms G. He is currently serving a life tariff with a minimum term of 18 years in prison.

2.24 After Mr S's trial, he was interviewed by the author of the Somerset Partnership NHS Foundation Trust's Serious Untoward Incident Report (SIR). The notes from the SIR reported that Mr S disclosed that on the day of the incident Ms G had made "uncharacteristic and insulting references"[66] in

[62] Police summary of incident

[63] Information obtained from police summary of incident

[64] Information obtained from police summary of incident

[65] Information obtained from police summary of incident

[66] SIR interview, p2

relation to Mr S's grandmother and that "he'd acted spontaneously whilst under the influence of alcohol and medication."[67]

3 Independent investigation

Approach to the 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,[68] 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 working. Looking at what was wrong in the system helps organisations to learn lessons that can prevent the incident recurring."[69]

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."[70]

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."[71]

3.4 In March 2015 NHS England (South) commissioned Niche Patient Safety to undertake an investigation into the events that led up to the homicide of Ms G on 6 August 2013.

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[67] SIR interview, p2

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

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

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

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

Purpose and scope of the investigation

3.5 The full Terms of Reference (TOR) for this investigation are located in appendix B. Briefly, Niche's investigation team has been asked to: review the engagement, assessment, treatment and care that Mr S received from Somerset Partnership NHS Foundation Trust, agency 1 and the relevant primary care service; consider the appropriateness of the care and treatment pathways in line with national standards and best practice; and to review the communication between agencies and services with regard to the assessment of risks and information sharing.

3.6 We were also asked to review the care planning and risk assessment for Mr S with particular consideration of how his cultural issues were considered and whether this was in line with the organisations' policies and procedures and in compliance with national standards and best practice.

3.7 We have also been asked to consider whether the incident on 6 August 2013, which led to the death of Ms G, was either predictable[72] or preventable.[73]

3.8 We have also been asked to review Somerset Partnership NHS Foundation Trust's Serious Untoward Incident Report (SIR) and the implementation of the Trust's action plan that arose out of the findings of the SIR.

3.9 The overall aim of this independent investigation is to identify common risks and opportunities, to improve patient safety and to make further recommendations about organisational and system learning.

Niche's investigation Team

3.10 The investigation was led by Niche's senior investigator Grania Jenkins.

3.11 During the course of our investigation, it became evident that Mr S's cultural background was a fundamental factor in his presentation and mental health problems. Therefore, to strengthen our exploration and provide specialist advice, Niche recruited onto the panel Dr Shanthy Parameswaran, a Sri Lankan psychiatrist who has extensive experience of working with refugees; Professor Rachel Tribe, Fellow of the British Psychological Society and an HCPC-registered psychologist, whose clinical interests focus on post-traumatic stress disorders and mental health in Sri Lankan survivors of war

[72] 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

[73] *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*

and torture; and Daniel Barrett, who was recruited to be a critical friend[74] to the panel.

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

3.13 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.

3.14 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.

3.15 This report was written with reference to the National Patient Safety Agency (NPSA) Root Cause Analysis Guidance.[75]

Methodology

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

3.17 RCA is a retrospective multidisciplinary approach designed to identify the sequence of events that lead to an incident. It is an iterative[76] structured process that has the ultimate goal of the prevention of future adverse events by the elimination of latent errors.

3.18 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.

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

3.20 As part of the investigation process, we have utilised an RCA fishbone diagram to assist the investigative team in identifying the influencing contributory factors which led to the incident.

[74] A critical friend has been defined as "a trusted person who asks provocative questions, provides data to be examined through another lens, and offers critique of a person's work as a friend". Costa and Kallick (1993) 'Through the Lens of a Critical Friend'. New Roles, New Relationships, Volume 51, 2, 49–51

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

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

3.21 Where relevant we have referred to national and local policies and guidelines, to the various Department of Health Best Practice[77] guidelines and to the relevant NICE[78] guidance.

3.22 As far as possible we have tried to eliminate or minimise hindsight or outcome bias[79] in our investigation. We analysed information that was available to primary and secondary care services at the time. However, where hindsight informed our judgments, we have identified this.

3.23 As part of this investigation we interviewed the following practitioners and senior managers from Somerset Partnership NHS Foundation Trust: Lead Criminal Justice Mental Health Practitioner; two consultant inpatient psychiatrists; Director of Governance and Corporate Development; Medical Director; Manager and CPN at Crisis Resolution and Home Treatment Service; and Head of the Adult Mental Health Inpatient and Assessment Division.

3.24 We also undertook interviews with members of Somerset Clinical Commissioning Group (CCG), acting Hub Manager and Senior Operations Manager for Turning Point[80] (referred to as agency 1 within this report), and Mr S's last GP.

3.25 We also interviewed the Senior Investigating Officer from Wiltshire Police Authority who led the police investigation. We also obtained a copy of the report by the Independent Police Complaints Commission (IPCC), which reviewed Avon and Somerset Police Authority's involvement with Mr S prior to the incident. However, as this report has yet to be published, we are unable to make any comments on its findings or recommendations.

3.26 Our interviews were managed with reference to the National Patient Safety Agency (NPSA) investigation interview guidance.[81] We also adhered to the Salmon/Scott principles.[82]

3.27 We accessed Mr S's primary and secondary mental health care notes as well as the relevant policies of Somerset Partnership NHS Foundation Trust. We were also provided with agency 1's records and accessed the police's

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

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

[79] *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)*

[80] Since this incident the service has been recommissioned and is now known as Somerset Drug and Alcohol Service

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

[82] 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

interview transcripts with Mr S and Ms G's partner as well as the report that was compiled by police for the trial.

Anonymity

For the purpose of this report:

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

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

3.30 The patient is referred to as Mr S and the victim as Ms G.

Involvement of Mr S and members of his and Ms G's families

3.31 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."[83]

3.32 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.

3.33 Both we and NHS England made repeated efforts to contact Mr S to explain the purpose of this investigation and to invite him to be involved. We were eventually informed that he had declined our invitation.

3.34 Once our investigation is concluded, we will contact Mr S to ascertain if he would like a copy of our report, and we will also offer to meet with him to provide verbal feedback on our findings and recommendations.

3.35 As far as we have been able to ascertain,[84] neither Mr S nor Ms G have family in the UK.

3.36 On Mr S's admission to hospital (28 January 2013), it was noted that he was accompanied by two friends and agreed for information to be shared with a named person who was identified as a "*flatmate*."[85] Neither NHS England nor Niche has been able to locate these persons in order to invite them to contribute to this investigation.

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

[84] Information supplied by Mr S's medical notes and also taken from the police who investigated the incident

[85] Nursing Admission and Assessment Record, 28 January 2013

3.37 We were also unable to locate the partner of Ms G to invite him to participate in our investigation. It was reported to us that since the incident he has relocated and no agency has his new contact details.

Structure of the report

3.38 This report has been divided into various sections. Where it is required, some sections have an arising issues and commentary subsection, which provides either additional information that we have obtained and/or a commentary and analysis of the issues that have been highlighted in that section.

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

3.40 We have provided a full chronology from the point Mr S came into contact with Somerset Partnership NHS Foundation Trust. This is located in appendix C.

4 Mr S's background and his entry into the UK

Childhood and family background

4.1 Mr S's country of origin was Sri Lanka. He was from the Tamil community and his religion was identified as being Hindu, although it was not identified if he was practising this religion when he was in the UK.

4.2 Mr S had reported to various agencies that in 1983, when he was five years old, his father was taken from the family home and was not seen again.

4.3 Mr S also repeatedly reported that on 21 April 1985,[86] when he was eight years old, he witnessed his mother committing suicide by drinking bleach. From this point his extended family, mainly his maternal grandmother, brought him up.[87]

4.4 Mr S provided some contradictory information regarding his family. It was documented[88] that Mr S reported that he did not have any siblings and that apart from his grandmother, all his family members had been killed in the civil war. However, we did note that on another occasion, Mr S reported[89] that since arriving in the UK he was no longer in touch with any of his extended family, who were living in Sri Lanka.

4.5 During an assessment at agency 1[90] Mr S reported that he had attended school and that he had enjoyed this time.

[86] Date provided in the Border Agency's report

[87] Information reported by inpatient consultant psychiatrist

[88] Comprehensive assessment by agency 1, 18 February 2013

[89] GP notes, 17 September 2008

[90] Comprehensive assessment, 18 February 2013

Mr S's entry into the UK

4.6 Mr S gave several slightly different accounts of the reasons surrounding him leaving Sri Lanka. During an inpatient detox assessment (12 March 2013), he reported that he had been involved in couriering mobile phones and maps to his friends and that on the third occasion he was arrested by the Sri Lankan army and imprisoned for one month, during which he was tortured. On another occasion he reported that he had been arrested by the Sri Lankan army for being a member of the Tamil Tigers[91] and was imprisoned for "2 to 3 weeks"[92] and that during his imprisonment he had been beaten and tortured.

4.7 Mr S consistently reported that he had bribed himself out of imprisonment and that an "uncle"[93] arranged for him to enter the UK.

4.8 On another occasion Mr S reported that when he left Sri Lanka he undertook a journey across Europe and that on his arrival in the UK he applied for and was granted political asylum.[94]

4.9 Mr S reported that when he arrived in the UK he initially stayed with a Tamil family in London, but he had found the experience "*humiliating*"[95] and after a month the family had asked him to leave.

4.10 However, during the course of our investigation, we accessed information from the Border Agency which contradicts some of Mr S's accounts of his arrival into the UK.

4.11 Records indicate that on 31 May 2004 Mr S applied to the British High Commission in Colombo, the capital of Sri Lanka, for a three-week business visa to the UK.

4.12 On 2 June 2004 he was issued with the Entry Clearance, valid for entry between 31 May 2004 and 22 June 2004 "on condition that work and recourse to public funds was prohibited."[96]

4.13 The exact date that Mr S entered the UK is not known, but we do know that Mr S overstayed the terms of his visa and remained in the UK. He next came to the attention of the Home Office on 21 May 2008, when they were informed by the police that he had been arrested in Scotland in relation to a criminal matter.

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[91] Tamil Tigers: aka Liberation Tigers of Tamil Eelam (LTTE). Guerrilla organisation that sought to establish an independent Tamil state in northern and eastern Sri Lanka

[92] Primary care notes, 19 September 2008

[93] RiO notes, 12 March 2013

[94] In Sri Lanka the term uncle does not necessarily refer to a blood relative

[95] Interview with inpatient consultant psychiatrist

[96] Information on statement provided by Border Agency, p1

4.14 Mr S attended the Sheriff Court (21 May 2008) to apply for asylum in the UK, and he was served with a "Notification Of Temporary Admission To A Person Who Is Liable To Be Detained under the Immigration Act 1971 (and) Notice To A Person Liable To Removal From The United Kingdom under the Immigration Act 1971, as amended, as an overstayer."[97]

4.15 On 11 August 2008 Mr S was issued with an Application Registration Card in connection with his asylum application which stated that employment was prohibited.

4.16 It is not evident what occurred or where Mr S was living between August 2008 and 26 October 2010, when his application for asylum was refused. One of the reasons that he was being refused asylum was that he had left Sri Lanka on his own passport, which indicated that he was not, as he claimed in his asylum application, in fear of the Sri Lankan authorities. He was however granted the right to appeal.

4.17 On 11 November 2010 solicitors lodged an appeal on behalf of Mr S. His case was heard on 2 December 2010, and he was granted leave to remain in the UK until 10 February 2016 with no restrictions.

4.18 On 3 August 2011 Mr S was issued with a Travel Document which allowed him to travel to all countries, with the exception of Sri Lanka.

Arising issues, comments and analysis

4.19 For the various clinicians who were supporting Mr S and for the readers of this report to fully understand Mr S's experiences and what may have been the aetiology[98] of his mental health issues, his presentations and his alcohol dependency, we feel that it is important to provide a brief description of the complex and bitterly fought 26-year civil war in Sri Lanka, as this was the backdrop of Mr S's formative years, as both a child and a young man.

4.20 Briefly, in 1983 the ongoing ethnic tensions between the majority Sinhalese (mainly Buddhist) population and the Tamil (mainly Hindu) minority erupted into civil war. Various Tamil groups – in particular the Liberation Tigers of Tamil Eelam (LTTE), more colloquially known as the Tamil Tigers – fought against the Sri Lankan army for control of the north-east of the country, with the aim of creating an independent Tamil state. The north and east of the country, which is where we believe Mr S's family originated, was home to the minority Tamils, and it is reported that this area bore the brunt of the civil war. The precise death toll is not known, but the United Nations suggests that between 1983 and 2009, it was estimated that between 80,000 and 100,000 people were killed, with many injured on both sides.[99]

[97] Information on statement provided by Border Agency, p2

[98] The word "aetiology" is mainly used in medicine, where it is the science that deals with the causes or origin of disease, the factors which produce or predispose towards a certain disease or disorder

[99] https://en.wikipedia.org/wiki/Casualties_of_the_Sri_Lankan_Civil_War

4.21 Mr S was 6 years old when the civil war began, and within two years he had lost both his parents. Clearly he grew up in an era of "*violence, counter violence, terror and counter terror*."[100]

4.22 In order for us to have an understanding of Mr S's behaviours and presentations, it was evident that we needed to have an understanding of the psychological impact of growing up in such a violent and enduring civil conflict. Therefore, we have undertaken an extensive review of the research that is available with regard to these issues. It is suggested that as a result of the civil war, Sri Lanka experienced "war trauma, multiple displacements of family units, injury, detentions, torture, and loss of family, kin, friends and homes."[101] It has also been stated that "the Sri Lankans have lived in an atmosphere of uncertainty and fear. The Tamil minority in particular have grown accustomed to living with high anxiety, including fear of annihilation - as if this was part of the normal reality of their lives."[102]

4.23 Research also indicates that as a result of the trauma of this civil war, complex mental health and psychosocial problems often developed at an individual, family and community level. These included "unresolved grief, individual and collective trauma; insecurity, self-harm and suicides; poverty and unemployment, alcoholism, socially irresponsible behaviour; distrust, hopelessness, and powerlessness."[103] It is also well documented that such a violent and complex war can cause dysfunctional behaviours and psychiatric disorders in individuals that result in "conditions like Acute Stress Reaction (ASR, the old disaster syndrome), Post-Traumatic Stress Disorder (PTSD), depression, anxiety, somatoform disorders, alcohol and drug abuse … Chronic long-term trauma can lead to complex PTSD … [and] enduring personality changes."[104] It is also suggested that on an individual level, Sri Lankans' psychological response to their country being subjected to such heavy security and violence was that "suspicion of others became normal strategies."[105]

4.24 It is with these issues in mind that we have reviewed Mr S's mental health, his alcohol dependency, and his relationship with Ms G and her partner as well as agencies' responses to his presentation and behaviours.

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[100] *Collective trauma in northern Sri Lanka: Daya Somasundaram, a qualitative psychosocial-ecological study. International Journal of Mental Health Systems 2007, 1:5 doi:10.1186/1752-4458-1-5, published 4 October 2007*

[101] *Rebuilding community resilience in a post-war context: developing insight and recommendations - a qualitative study in Northern Sri Lanka, International Journal of Mental Health Systems 2013, 7:3 doi:10.1186/1752-4458-7-3 Published 11 January 2013, p76*

[102] *Rebuilding community resilience in a post-war context: developing insight and recommendations - a qualitative study in Northern Sri Lanka, International Journal of Mental Health Systems 2013, 7:3 doi:10.1186/1752-4458-7-3* Published 11 January 2013, p9

[103] A Critical Review of the Evolution of the Children's Play Activity Programmes Run by the Family Rehabilitation Centre (FRC) throughout Sri Lanka. Journal of Refugee Studies, 17, 1, 114–135

[104] A Critical Review of the Evolution of the Children's Play Activity Programmes Run by the Family Rehabilitation Centre (FRC) throughout Sri Lanka. Journal of Refugee Studies, 17, 1, 114–135

[105] *Tribe, R. & Calvert, H. (2011). Moving forward together? Legacy issues in post conflict Sri Lanka. International Journal of Migration, Health and Social Care, 7, 3, 131–138, p3*

5 May 2008 to May 2012

5.1 We have been unable to ascertain any information regarding Mr S's psychiatric or physical health history from his arrival in the UK in 2004 until 29 May 2008, when he first registered with a primary care service in Scotland.

5.2 On one occasion Mr S reported that he had moved directly from London to Scotland, but during his inpatient assessment in March 2013, Mr S reported that he had also lived in Wales and Bristol before he moved to Scotland. During the course of our investigation we accessed Mr S's NHS Scotland Application to Register with a General Practitioner (15 July 2008), where we noted that prior to Mr S moving to Scotland he had lived at an address in Peterborough.

5.3 The registration details from the Scottish GP documented that from 29 May 2008 to 30 June 2008 he was living in an "induction centre"[106]and that he was an asylum seeker. From 23 July 2008 his address indicates that he had moved into accommodation in Glasgow, but it is unclear if this was a hostel or privately rented accommodation.

5.4 At the GP's initial registration assessment, it was documented that Mr S had two scars on his left arm and a scar on the left part of his back, which he reported were the results of an assault and burns caused by the police in Sri Lanka.[107] We noted that this was the only time where it was documented that a clinician had actually seen Mr S's scars.

5.5 From the first point of contact with primary care services, it was Mr S's excessive alcohol consumption, rather than any particular mental health issue, that was being identified by both Mr S and the GP as the main area of concern. During the initial assessment, it was documented that Mr S was reporting that he was drinking 3–5 units of alcohol a week, but when he felt depressed he was drinking to excess.

5.6 On 31 July 2008 Mr S presented to his GP with abdominal pain. It was documented that Mr S was a "binge drinker but not an alcoholic."[108] Subsequent blood tests indicated that Mr S's amylase was raised,[109] and he was referred for an ultrasound scan, which took place on 8 September 2008. The scan indicated that Mr S's gall bladder, pancreas, liver, spleen, kidneys and para-aortic lymph node were all normal and no further action was taken.

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[106] GP registration report, 27 July 2008

[107] GP registration appointment, 15 July 2008

[108] GP appointment 31 July 2008

[109] *Possibly due to pancreatic disease or gallstones. Diseases of the pancreas most commonly cause elevated amylase most frequently due to prolonged, excessive consumption of alcohol.* http://www.livestrong.com/article/122040-reasons-elevated-amylase-lipase

5.7 On 17 September 2008 Mr S disclosed to the GP that he was binge drinking and that he was feeling depressed. During the course of the consultation, Mr S became tearful whilst speaking about his mother committing suicide and admitting that he was no longer in contact with his family in Sri Lanka. He also disclosed that prior to coming to England he had been imprisoned and "beaten"[110] by the Sri Lankan police. The GP noted that Mr S "just keeps everything inside, doesn't really share feeling"[111] and that he had discussed with Mr S various support options. At the next GP appointment (24 October 2008), Mr S reported that he had stopped drinking and was feeling "a bit better."[112]

5.8 Mr S had no further contact with the GP until March 2010, when he presented with a benign breast cyst which was later removed.

5.9 The next entry in the primary care notes was over 12 months later (5 April 2011), when Mr S reported that he was now constantly drinking beer and spirits. The GP referred Mr S to an addiction treatment service. We located a discharge letter from this service (8 September 2011), which informed the GP that Mr S had attended two appointments, that he had reduced his drinking to one to two occasions a week, and that at his request he was to be discharged from the service. This, it appears, was the last primary care service entry until he moved to Somerset in 2012.

6 May 2012 to August 2013

The chronology of Somerset services' involvement with Mr S is located in appendix C. Therefore, it is our intention in this section to highlight and discuss the more significant events during this period:

6.1 When Mr S initially registered with the GP in Somerset (9 May 2012), he disclosed, on the new Patient Registration Form, that he was drinking 35 units a week.[113]

6.2 At Mr S's first consultation[114] it was documented that he was presenting with "low mood" and was reporting that he was consistently drinking in the evenings. He also disclosed that in the morning, if he had been drinking the previous day, he "sometimes wishes he hasn't woken up."[115] Mr S was also reporting that he was experiencing some upper abdominal pains, and on examination it was noted that there was some tenderness under his ribs. It is

[110] GP entry, 17 September 2008

[111] GP entry, 17 September 2008

[112] GP entry, 24 October 2008

[113] Royal College of Physicians recommends that adult males should not drink more than 21 units a week http://patient.info/health/recommended-safe-limits-of-alcohol

[114] 26 June 2012

[115] GP notes, 26 June 2012

not evident if Mr S disclosed that he had experienced similar symptoms whilst he was living in Scotland and that he had undergone some diagnostic tests.

6.3 The GP concluded that Mr S was not presenting with any active suicidal ideation and was "not addicted"[116] to alcohol, so there was no need for a detox programme to be considered. However, the GP clearly had some concerns regarding the amount of alcohol that Mr S was drinking, as he issued a prescription for Vitamin B Compound and Thiamine Hydrochloride[117] (100mg) and noted that he had advised Mr S that he needed to take this medication when he stopped drinking to "avoid damage to [his] brain." Mr S was also prescribed Amitriptyline[118] 25mg as an antidepressant.[119]

6.4 The next appointment Mr S had with the GP was on 28 August 2012, when his vaccinations and travel needs were discussed as he was going to India for ten days. There was no documentation to suggest that the issues that had been identified in the previous appointment, in relation to Mr S's low mood, alcohol use or medication, were discussed at this or at subsequent appointments. We did note that no further prescriptions were issued, so it is unclear if Mr S was taking this medication. He had no further contact with his GP until he came to the attention of secondary mental health services in January 2013.

6.5 On 15 September 2012 Mr S was arrested for drink-driving and failing to provide a specimen (15 September 2012). During his custody booking, a Custody Alcohol Test form was completed where it was noted that Mr S reported that he wanted help with his drinking. The Alcohol Arrest Referral Worker saw Mr S and gave him an appointment to attend agency 1's[120] custody drop-in centre.

6.6 Mr S subsequently attended an assessment appointment (19 September 2012) with agency 1, where he reported that whilst he was living in Scotland he had made three suicide attempts. He provided details of the following two incidents. In 2007, whilst in police custody, he had attempted to asphyxiate himself with a cord, and on another occasion he had attempted to jump from a window on the 22nd floor of a building but was prevented from doing so, as the window would not open far enough.[121] He also reported that he had been referred to counselling. We noted that details of these attempts were not documented within the Scottish primary care notes that we located.

[116] GP notes, 26 May 2012

[117] Thiamine Hydrochloride, Vitamin B1: Thiamine deficiency can lead to metabolic coma and death. A lack of thiamine can be caused by a grossly impaired nutritional status associated with chronic diseases, such as alcoholism

[118] Amitriptyline is a tricyclic antidepressant

[119] Commencing 1 nocte for 1 week, 2 nocte for 1 week and 3 nocte thereafter

[120] Agency 1 is an alcohol and drug service. Now after a retendering process it is a partnership between three services and is called the Somerset Drug and Alcohol Service

[121] Substance Misuse Referral Form, 19 September 2012

6.7 When asked about his history of drinking, Mr S reported that he had started to drink when he was 22, but that his drinking had only become a problem when he was 28. He also reported that he was currently drinking one bottle of whisky every two to three days and was also drinking up to eight pints of lager at any one time.

6.8 Mr S reported that when he drank he felt that he was a "bad person … He has discussed cutting his throat and hanging himself … He feels a sense of failure that his attempts at suicide have failed."[122] The only protective factor that Mr S is documented as being able to identify was that he "was able to rationalise his behaviour and also reports a strong moral ethic that would prevent him acting on these thoughts. He feels an obligation to his maternal grandmother."[123]

6.9 The assessor completed a Severity of Alcohol Dependence Questionnaire (SADQ) and Alcohol Use Disorders Identification Test (AUDIT); both identified that Mr S was within the alcohol dependency range.[124]

6.10 Mr S cancelled two subsequent appointments with agency 1 (15 and 17 October 2012). It was documented by the support worker that during a subsequent telephone discussion with Mr S (20 October 2012), Mr S was upset by the report in the local paper relating to his court hearing for drink-driving, where he had received a 42-month driving ban, and that it was affecting his work.

6.11 During a subsequent telephone conversation (23 October 2012) with agency 1, Mr S was offered a further assessment appointment, and his response was that he "would attend if he was still alive."[125]When asked to explain how he was feeling, it was documented that he alluded to suicidal thoughts, but said that he would not do this as long as his grandmother was alive. After a discussion between Mr S's case worker and a co-worker, it was agreed that although Mr S was expressing some concerning suicidal thoughts, he had also expressed a number of protective factors, so it was agreed that no immediate action should be taken.

6.12 At his next appointment at agency 1 (29 October 2012), it was noted that Mr S apologised for what he had said during the last phone call, saying that he had been drinking and that he had been feeling "very stressed."[126] He also reported that he had been trying to stop drinking, but when he did he could not sleep and was experiencing nightmares. He reported that drinking was the only way he could stop his feelings of stress, albeit on a temporary basis. Mr S also claimed that he was keen to start agency 1's self-help course, but that

[122] Agency 1 links care pathway notes

[123] Agency 1 links care pathway notes

[124] Agency 1 triage assessment, 29 October 2012

[125] Agency 1 contact notes, 24 October 2012

[126] Agency 1 notes, 29 October 2012

he first wanted to complete the DVLA training course, which was the requirement relating to his drink-driving offence.

January 2013 to March 2013

6.13 On 28 January 2013 police arrived unexpectedly at Mr S's flat to discuss an incident that had occurred the previous evening, where Mr S had allegedly been attacked by a man in a pub toilet. They noticed that Mr S was very drowsy and uncoordinated, and eventually he disclosed that he had taken an overdose. Police requested that paramedics be dispatched to Mr S's accommodation, and the attending paramedics ascertained from Mr S that he had taken 12 tablets of Amitriptyline and Thiamine Hydrochloride. He was transported to an A & E department.

6.14 The A & E initial assessment document noted that Mr S was unable to give a coherent account of recent events and disclosed that prior to taking the overdose he had drunk six pints of alcohol, and that he had taken an overdose two years before.[127] During the assessment, it was documented that Mr S was saying that "he wants to kill himself."[128]

6.15 The assessment report documented that the two female friends who had accompanied Mr S to A & E reported that his "recent behaviour was not usual for him"[129] and that they had noticed that he had also recently lost a significant amount of weight. Despite this information, we noted the risk screen, which was completed in A & E, identified Mr C's physical health condition as being a low risk (1). There was also no further documentation about his recent weight loss in the Risk Information Form and no reference to this in any subsequent assessments.

6.16 Mr S was given chlordiazepoxide[130] (30mg) and diazepam (5mg) in A & E to prevent symptoms of alcohol withdrawal. It was assessed that, based on Mr S's presenting symptoms, he was experiencing a "mental and behavioural disorder due to use of alcohol."[131]

6.17 It was documented that Mr S had disclosed that he was having difficulties with his flatmate and his girlfriend, who he said were "always winding him up with constant insults and phone calls"[132] and that there were "other Sri Lankans with whom he has difficulties."[133] He also accused his flatmates of burning and poisoning him. It was also documented that Mr S had a burn mark on a

[127] Assessment 28 January 2013, 14:23

[128] Hospital admission notes

[129] Hospital admission notes

[130] Chlordiazepoxide Hydrochloride Capsule is indicated for the management of anxiety disorders or for the short-term relief of symptoms of anxiety, withdrawal symptoms of acute alcoholism

[131] Progress notes, 28 January 2013, 23:14

[132] RiO notes, 29 January 2013, 9:33

[133] RiO notes, 29 January 2013

tattoo on his shoulder, which Mr S reported was either caused by his flatmates, who "may have burnt him … or he may have fallen on a flame while intoxicated."[134] He also reported that he was hearing voices. Information we have obtained from the police's interview confirms that Mr S, Ms G and her partner were living together at this time.

6.18 The admitting doctor in A & E assessed that Mr S "may be at risk of physical and psychological harm from his flat mates and that there was some evidence to suggest that he could be experiencing paranoid beliefs about his flat mates."[135]

6.19 It was assessed that although it was difficult to formulate an accurate impression of Mr S's mental state, it was possible that there might be abuse from his flatmates, and because he was presenting with a number of significant high risk factors it was decided that he should be admitted to an inpatient unit for observation and further assessment for a possible psychotic illness. It was also suggested that "medics may wish to consider alcohol detox."[136]

6.20 A risk screen was completed by a member of the Crisis Resolution and Home Treatment Team (CRHT) whilst Mr S was in A & E: it identified that Mr S's acute risks of suicide, accidental self-harm and neglect/abuse/exploitation by others were significant (scored 2)[137]. The long-term risk section was not completed.

6.21 The Trust's Clinical Assessment and Management of Risk to Self and Others Policy that was in situ at the time directed that: "Any screening factors that rate as 'significant' or 'high' triggers the completion of the RiO Risk Information and actions to mitigate identified risk should then be incorporated directly into the RCPlan."[138] As per Trust policy, the assessor correctly completed the Risk Information pro forma identifying both Mr S's "static factors"[139] and his "dynamic factors."[140] The following current and historical risk factors were identified: Mr S had reported that he had intended to die; he had not disclosed his actions to anyone; he was unable to explain his triggers that had led up to this incident; he had alcohol dependency issues; and he had possible psychotic symptoms. It was also noted that Mr S's mother's

[134] Mental State Assessment, 29 January 2013, 00:50

[135] RiO notes, 29 January 2013, 9:33

[136] Summary/formulation/opinion, 29 January 2013, 00:52

[137] A score of 2 is a significant risk that requires further appraisal via risk information and consideration within the recovery plan

[138] Somerset Partnership NHS Foundation Trust, Clinical Assessment and Management of Risk of Harm to Self and Others Policy, August 2012, p21

[139] Somerset Partnership NHS Foundation Trust, Clinical Assessment and Management of Risk of Harm to Self and Others Policy, Static factors identified are unchangeable, e.g. a history of child abuse or suicide attempt, p16

[140] Somerset Partnership NHS Foundation Trust, Clinical Assessment and Management of Risk of Harm to Self and Others Policy, Dynamic factors are those that change over time, e.g. misuse of alcohol, p16

suicide was an "actuarial indicator"[141] and therefore he was considered to be "more at risk of ending his own life."[142]

6.22 Given the fact that Mr S's mother's suicide was considered as both a very high risk and one that the policy identified as a static risk factor, i.e. unchangeable, we were concerned to note that in this initial and in subsequent risk screenings, Mr S's long-term risk of suicide was being scored as low (1).

6.23 We also noted that the section Summary of Key Action to Manage Risk within the Risk Information Form was not completed either in A & E or prior to Mr S's discharge from the inpatient unit.

6.24 The Clinical Assessment and Management of Risk to Harm to Self and Others Policy directs that for patients who have been assessed as having significant or high risk triggers a Recovery Care Plan (RCPlan)[143] should be completed which should be identifying risk management actions within the plan. However, we were unable to locate an RCPlan until 10 February 2013, when Mr S was discharged from the CRHT.

6.25 After seeing the inpatient consultant, Mr S was discharged the following day and he was referred to the CRHT, who saw him on four occasions from 31 January to 10 February.

6.26 At CRHT's initial visit, Mr S disclosed that he was drinking double the amount that he had reported to the psychiatrist. He also disclosed that he was experiencing considerable financial difficulties, as he was in debt by about £3,000 and was imminently to become unemployed and homeless. The CRHT documented that they had advised Mr S to contact agency 1 to access support for his drinking and also attend both the housing department and benefit offices.

6.27 The CRHT completed a risk screen after Mr S was discharged from their care. It noted that he had no acute risk and his long-term risk of suicide and deliberate self-harm had been downgraded to low (1). As this assessment had not triggered the completion of a Risk Information Form, there was no narrative to explain Mr S's acute or long-term risk factors of suicide. We have assumed, however, that it refers to the risk associated with his mother's suicide.

6.28 A CPA review undertaken by CRHT (9 February) documented that Mr S had no ongoing significant mental health issues and was to be discharged from the CRHT service.

6.29 On 14 February 2013 Mr S was taken to A & E as he had collapsed. He is reported to have stated that he had drunk a bottle of whisky and some other

[141] Actuarial indicator: risk according to probabilities based on statistical records

[142] Risk Information, 29 January 2013, 00:44

[143] RCPlan, Recovery Care Plan

alcoholic drinks. On admission Mr S was reported to have made some "generalised comment about his life not being worth living."[144] Staff contacted the on-call CRHT for background information, and Mr S was subsequently discharged.

6.30 On 27 February Mr S had an assessment with a doctor at agency 1. In the assessment letter, which was only sent to the GP, it noted that Mr S was "deeply traumatised by the loss of both parents in childhood and other aspects of the conflict – pt himself was tortured by the Sri Lankan military. Has no social support network locally. Pt very vulnerable – has been swindled previously by 'friends'. Pt not really eating – spending any money he has on alcohol."[145] The assessment concluded that "Pt not suitable for community detox – will need in-patient detox with psychiatric input"[146] and that agency 1 intended to arrange an inpatient admission.

6.31 We noted that this letter made no reference to Mr S's disclosure, on 19 September 2012, regarding his previous suicide attempts or the concerns on 23 October 2012 that he was actively suicidal. We would suggest that it would have been helpful if agency 1 had passed this information on to Mr S's GP, who was, at this time, the only statutory service involved in the care of Mr S.

Inpatient admission (6 March 2013 to 18 March 2013)

6.32 On 6 March 2013 Mr S was arrested by police and charged with being drunk and disorderly. As the custody sergeant had concerns about Mr S's mental health, he was referred to the Court Assessment and Advice Service (CAAS). During CAAS's assessment, they documented that Mr S had disclosed that he "would kill myself if I had a chance … that he was a waste of time and a nuisance to everyone … and that he prays to god every day to take me away."[147] It was identified that there were two significant precipitators to Mr S's current state of mind – the recent losses of his job and his home. CAAS assessed that Mr S's risk of suicide was significant and he was referred to the CRHT.

6.33 Mr S was assessed[148] by a CRHT nurse who had also undertaken Mr S's previous assessment in A & E (29 January 2013). She documented that as part of her assessment she had liaised with agency 1 and the police to obtain background information about Mr S's current presenting issue. However, in our review of the RiO notes, it was evident that the police had not communicated the full extent of their involvement with Mr S since January 2013 (please refer to section 9). We would suggest that it would have been really helpful if the police had provided a full account of their involvement with Mr S, as this would have provided CRHT with a more comprehensive and

[144] RiO notes, 20 February 2013

[145] Letter to GP from agency 1 Speciality Doctor

[146] Letter to GP from agency 1 Speciality Doctor

[147] RiO notes, 7 March 2013

[148] 7 March 2013

current profile of Mr S's circumstances. We would also suggest that it would have been helpful if the CRHT had liaised with Mr S's GP.

6.34 During the assessment Mr S reported that recently he had stopped drinking alcohol for two days and that he was experiencing "voices again."[149] He also described "periods of blackout where he cannot remember anything, he will find himself somewhere and not remember how he got there."[150] He also reported that his wish was "to be dead."[151] The assessment concluded that there was evidence of low mood, although it was "difficult to distinguish between clinical indicators of depression and the effects of alcohol … Full assessment of mood cannot be undertaken until alcohol dependence has been addressed."[152] Despite Mr S's disclosures, the risk screen that was completed at the assessment identified Mr S's acute and long-term risks of suicide, deliberate self-harm, neglect, abuse and exploitation by others as low (1).

6.35 Just prior to this assessment, the CAAS worker had documented that Mr S had "described loss of appetite and over the past 6-7 months, has lost 2 stone in weight … can go 2-3 days without eating."[153] We would suggest that based on this disclosure, we would have expected the risk screen to reflect this by identifying that Mr S was at a significant acute risk of self-neglect.

6.36 The assessment concluded that agency 1 was responsible for arranging an inpatient detox, but there was no evidence of any liaison between CRHT, CAAS or agency 1.

6.37 Later that day Mr S was detained by the police on an s136 after he was found lying on a railway line. A witness who was on the platform reported that Mr S had asked her what time the next train was and then walked onto the train track and proceeded to lie down. Police took Mr S to the s136 suite at the hospital, where it was documented[154] that he was stating that if he was discharged he would end his life.

6.38 A Mental Health Act (MHA 1983) assessment was undertaken (8 March 2013). The assessment documented that Mr S was consistently expressing suicidal thoughts, and at one point he is reported to have stated that "I should not be alive."[155] He also reported that he had been attempting to reduce his

[149] RiO notes, 8 March 2012, CRHT assessment

[150] RiO notes, 8 March 2012, CRHT assessment

[151] RiO notes, 8 March 2012, CRHT assessment

[152] RiO notes, 8 March 2012, CRHT assessment

[153] RIO CAAS assessment, 7 March 2013

[154] RiO notes, 8 March 2013, 18:27

[155] Assessment Form for Use By Approved Mental Health Professionals (AMHPs) When Making An Assessment Under The Mental Health Act 1983

drinking for the last two weeks and that he had been hearing voices and experiencing hallucinations.

6.39 The approved mental health professional (AMHP)[156] assessment noted that Mr S had initially agreed to be a voluntary patient, but when he was told that there was not a local bed available and that he would have to be admitted to another unit some miles away, he said that he wanted to leave but would return the next day. However, such was the concern regarding Mr S's suicide risk that he was placed on a Section 2 MHA and transported to the hospital, where he underwent an alcohol detox programme (Chlordiazepoxide-reducing regime- Thiamine and vitamin B).

6.40 Mr S's formulation[157] on admission to the inpatient unit was "alcohol dependency."[158] However, the assessing inpatient consultant was of the opinion that "following the alcohol detox [Mr S's] low mood will remain. At this stage mental health services will likely be required. At present any treatment for depressive illness or PTSD is going to be ineffective due to severe alcohol use. Once alcohol use has been addressed referral for therapeutic interventions will likely be very appropriate."[159]

6.41 A risk screen, completed the following day (9 March), documented that Mr S's acute risks of suicide, deliberate self-harm and accidental self-harm and neglect were significant. However, we were unable to locate the required Risk Information Form. This contravened the Trust's policy[160] at the time, which stated that "the RiO Risk Information Functionality should be reviewed and revised every time there is a change in the perceived risk, at the client's, or carers, request or when any items from the Risk Screen functionality achieve a level of 'significant' or 'high.'"[161]

6.42 During Mr S's admission it was consistently noted that he engaged well with his detox programme and there was no evidence that he was drinking when he was out on leave. On 15 March 2013, following a risk assessment which identified that Mr S's risk to others and himself was low, his s2 was removed. He remained on the ward as a voluntary patient until the end of his detox programme on 18 March. Mr S's discharge medication was Mirtazapine[162]

[156] AMP: Approved Mental Health Professional

[157] In clinical practice, formulations are used to communicate a hypothesis and provide a framework for developing the most suitable treatment approach

[158] Summary/formulation/opinion, 8 March 2013

[159] Summary/formulation/opinion, 8 March 2013

[160] Somerset Partnership NHS Foundation Trust's Clinical Assessment and Management of Risk to Self and Others Policy

[161] Clinical Assessment and Management of Risk of Harm to Self and Others Policy, p24

[162] Mirtazapine: an antidepressant

30mg q.d.s.[163] and Diazepam 5mg, initially q.d.s. to be reduced to b.i.d[164] daily on 20 March.

6.43 The discharge plan identified that Mr S's allocated care coordinator from the CRHT team would support him with regard to employment. He would also re-engage with agency 1 for ongoing community support for his alcohol dependency and a referral would be made for PTSD psychotherapy.

Arising issues, comments and analysis

6.44 One of the significant issues that this case has repeatedly highlighted was the systemic lack of information sharing between agencies about Mr S. We ascertained that apart from a joint agency protocol between Avon and Somerset Police Authority and Somerset Partnership NHS Foundation Trust, which specifically relates to s136 and s135 place-of-safety provisions; there is no protocol in place regarding information sharing between agencies. We have been informed that since this incident, a multi-agency Information Sharing Protocol[165] has been developed and implemented in Somerset. This protocol provides an overarching framework for the sharing of service users' personal information across health and social care sectors within Somerset. Both agency 1 and Somerset Partnership NHS Foundation Trust as well as the local police authority have adopted this protocol. The underpinning ethos of this protocol is to "share information to safeguard and promote the well-being of our service users whilst recognising our duty of confidentiality and the right to privacy in respect of their personal information."[166] One of the areas identified for agencies to share information is for the purpose of risk management and the delivery of effective personal care, treatment and advice.[167] We concluded that clearly such a protocol provides greater clarity with regard to information sharing; however, in this case, if this protocol had been in place it is unlikely that it would have altered the course of events, as Mr S was not considered a high-risk patient and there was no evidence to indicate that Ms G was at significant risk.

6.45 During Mr S's first contact with CRHT (31 January 2013), he disclosed a number of significant issues that he was experiencing. He was in considerable financial difficulties, was in debt by about £3,000 and was also imminently to become unemployed and homeless. The CRHT documented that they advised Mr S to attend both the housing department and benefit offices. There was no indication that they or any other agency provided him with information or supported him to access either Citizens Advice or other advocacy services that could have supported him with these issues. We would suggest that it was not realistic to have expected someone with such complex issues as Mr S was experiencing at the time, compounded by the fact that his first

[163] Q.d.s. four times daily

[164] B.i.d.: twice daily

[165] October 2014

[166] Somerset Information Sharing Protocol 2014, p7

[167] Somerset Information Sharing Protocol 2014, p11

language was not English, to navigate the complexities of the housing and benefits systems.

6.46 We are unclear as to why, despite it being recognised that Mr S's mother's suicide was an "actuarial indicator"[168] and he was therefore considered, both acutely and in the longer term, to be "more at risk of ending his own life,"[169] apart from during his admissions to hospital in January and March 2013 he was being assessed as being at low risk of suicide. When we referred to the Trust's Clinical Assessment and Management of Risk to Self and Others Policy, we noted that it clearly identified the suicide of a close family member as being a static, ongoing and high risk. This assessment is compatible with various research data that indicates that "exposure to suicidal behaviour in peers and relatives is thought to increase risk for suicidal behaviour in vulnerable individuals … Offspring reporting exposure to suicidal behaviour were four times more likely to report a lifetime suicide attempt compared with unexposed offspring."[170] Based on such evidence and the clear directive within the Trust's policy, we would suggest that until such time as Mr S had undergone psychological therapy and it had been assessed that he was no longer at significant risk of suicide, it should have been continually identified that Mr S was at acute and long-term significant risk of harm to himself. This would have triggered a full risk history to have been documented that would have alerted agencies to Mr S's history and the fact that this was a consistent high risk factor.

6.47 We also noted that whilst Mr S was in A & E, the admitting doctor and also a member of the CRHT documented that they had some difficulty understanding Mr S due to his level of sedation, his strong accent and the fact that he was often reverting to his native language. The Trust's Clinical Assessment and Management of Risk Policy (2012) states that "where the patient does not speak English, or does so as a second language, or has a sensory impairment, staff should consider requesting a suitable interpreter to be present when making the assessment."[171] We could find no documented evidence from Mr S's contact with either primary or secondary care services to indicate if any agency either considered the option of utilising an interpreter or asked Mr S if it would have been helpful for an interpreting service to be used.

6.48 During an assessment undertaken by the CAAS after Mr S had been arrested (6 March 2013), it was documented that he "describes loss of appetite and over the past 6-7 months has lost 2 stone in weight … can go 2-3 days without eating."[172] We were concerned that despite Mr S's repeated

[168] Actuarial indicator: risk according to probabilities based on statistical records

[169] Risk Information, 29 January 2013, 00:44

[170] Effect of Exposure to Suicidal Behaviour on Suicide Attempt in a high-risk sample of Offspring of Depressed Parents http: //www: //www.ncbi.nlm.nih.gov/pmc/articles/PMC2915586/

[171] Somerset Partnership NHS Foundation Trust, Clinical Assessment and Management of Risk of Harm to Self and Others Policy, August 2012, p5

[172] RiO notes entry, 7 March 2013

disclosure to various agencies regarding the extent of his alcohol dependency, his lack of nutrition and visual presentation, for example “baggy clothes”[173] this did not trigger any documented concern or action by the inpatient unit, primary care, community mental health services or agency 1 regarding the potential and very significant physical health risks of Mr S’s lifestyle. Even when Mr S himself was reporting that he had lost a significant amount of weight, there was no evidence to indicate that any agency was identifying or considering that he may have been potentially at significant risk of malnutrition.

6.49 When we reviewed Mr S’s papers for this admission, we noticed that amongst the assessments a Physical Health Examination Assessment was completed (9 March 2013). However, this assessment form was only partially completed, and it is unclear if Mr S was actually physically examined, as the section relating to this was blank. We were concerned about the lack of a comprehensive physical health examination being undertaken, as, given the fact that it was known that Mr S was abusing alcohol; there was clearly a significant and ongoing risk to his physical health. This admission would have been an ideal opportunity for a comprehensive physical health check to have been undertaken.

6.50 It was repeatedly documented that the police reported that Mr S had a number of scars on his upper body that were from him being tortured, by a welding torch[174] as a young man in Ski Lanka. During our extensive review of all Mr S’s primary and secondary notes, we were unable to locate any instance where there was visual sighting or documented details of Mr S’s scars. When we asked staff why they had not asked to see or document the details of the scarring, they reported that they had felt that it was such an emotive issue for Mr S that they did not feel it was appropriate to discuss this issue with him or ask to see his scars. Although we do appreciate that this was a sensitive issue to address with Mr S, we do have concerns about the lack of detailed records based on visual observations of Mr S’s scars being documented within any of his primary or secondary health care records. We would suggest that without accurate records of the marks on Mr S or indeed any other patient’s body, the patient and those providing the care are in somewhat of a vulnerable position. Medical staff do need to have visual sighting of any scars etc. on a patient’s body in order to assess if they are in need of treatment or possibly being physically abused. For the safety and protection of both patients and staff, we would suggest that within RiO’s Physical Health Examination pro forma there should be a body map that is used, with the patient’s permission to record all injuries, scars. Due to the potential sensitivity of this we would suggest that if Somerset Partnership NHS Foundation Trust decide to include a body map within their assessments process they will need to issue clear guidelines for staff that include obtaining a patient’s permission.

[173] RiO notes entry, 8 March 2013

[174] Documented in discharge summary, 18 March 2013, as “believed were inflicted using a welding torch”

Somerset Partnership NHS Foundation Trust:

Recommendation 1:
When assessing and providing support to patients whose first language is not English, primary and secondary care services must always consider the option of utilising an interpreting service.

Somerset Partnership NHS Foundation Trust:

Recommendation 2:

Where it is known that a patient is experiencing financial or housing issues etc., secondary mental health services should be identifying, as part of the patient's care planning, details of the relevant advocacy and support services and supporting them in accessing such services.

Somerset Partnership NHS Foundation Trust:

Recommendation 3:

Where static long-term and acute risk factors have been identified as being significant, they must continue to be assessed and documented at this level until such time as it can be evidenced that there has been a significant change in a patient or that there are new robust protective factors in place.

Somerset Partnership NHS Foundation Trust:

Recommendation 4:

For the safety and protection of both patients and staff, RiO's Physical Health Examination pro forma should include a body map that is used, with the patient's permission, to record any injuries, scars, bruises etc. on a patient's body. Somerset Partnership NHS Foundation Trust should introduce the appropriate guidelines regarding the use of body maps.

March 2013 to August 2013

6.51 Prior to Mr S's discharge from his inpatient detox programme, a care coordinator from the CRHT was allocated and both a Risk Screen and Crisis Plan were completed. The risk screen identified Mr S's long-term and acute risks of suicide, deliberate and accidental self-harm and

neglect/abuse/exploitation from others as low risk (1). The direction within the risk screen form to the assessing practitioners is that when a risk has been scored as low (1), they should "use discretion as to whether or not to document further via Risk Information and Recovery Care Plan." In this incident it appears that the practitioner did not feel it necessary for a Risk Information form to be completed.

6.52 The Trust's policy directs that a patient's Recovery Care Plan must identify a patient's support needs that are required in order to mitigate the risks identified within a risk screen. Mr S's Recovery Care Plans did not identify any of the identified risks highlighted within his discharge risk screen.

6.53 By 27 March 2013 primary and secondary health care agencies became aware that Mr S had relapsed and was drinking alcohol again, and there were several telephone discussions between agency 1 and the GP with regard to what support they could offer Mr S. It was agreed (28 March 2013) that as he was unwilling to engage with the service or his abstinence programme, he was discharged from their service.

6.54 On 31 March 2013 Mr S was admitted to A & E following a suspected overdose of prescribed medication. It was documented that Mr S had disclosed that he had been drinking. An assessment by the CRHT team documented that Mr S "seemed to think he cannot stop drinking, asking rather to be locked away for a number of years."[175]

6.55 The CRHT worker noted that "because of a number of recent contacts with Secondary Mental Health Services, including 1 admission I have not completed a full assessment. Rather I have focused on the reason for his presentation, mental state and risk."[176] This contravened the Trust's policy at the time, which clearly directs practitioners that Risk Screens should be updated "after every risk incident."[177]

6.56 The assessment concluded that Mr S was at high risk of misusing prescribed medication "either to overdose on, or as a means for self-medicating. Therefore his supply of medication should be closely monitored by his GP."[178] From this point Mr S was only dispensed three days' worth of medication from the GP. However, despite this assessment it was documented that Mr S's "risk factor of suicide was low at present however this clearly increases when he is intoxicated. At such times he is more likely to take an impulsive overdose or engage in other risky behaviour."[179] He was discharged from the A & E unit.

[175] RiO notes, 31 March 2013

[176] RiO notes, 31 March 2013, 11:04

[177] Somerset Partnership NHS Foundation Trust, Clinical Assessment and Management of Risk of Harm to Self and Others Policy, August 2012, p21

[178] RiO notes, 31 March 2013

[179] RiO notes, 31 March 2013

6.57 Based on the notes that were available from secondary care services, their last contact with Mr S was on 8 April 2013, when he was discharged from the CAAS service. From this point Mr S was only being monitored by his GP.

6.58 Up until 9 May Mr S was collecting his prescriptions every three days, although he was not always being seen by the GP; instead, prescriptions would be at the health centre's reception. Mr S did see the GP on 9 May, when it was noted that "patient condition is steadily improving. Making progress with financial affairs and getting a job, more positive, switch to weekly scripts."[180]

6.59 However, in our review of the police records, it was clearly evident that from that point to the incident itself, Mr S was far from stable (see section 9).

Arising issues, comments and analysis

6.60 We noted that Somerset Partnership NHS Foundation Trust's Clinical Assessment and Management of Risk Policy, which was in situ at the time, made repeated references to the importance of involving patients in their risk assessments and care plans. It stated: "All staff should ensure the outcome of the assessment and the resulting care plan is discussed with, explained to and given to the patient, and where appropriate their carer, in a language and format which they are easily able to understand."[181] We concluded that the Trust's Risk Assessment format focuses on the professionals' assessment. It is not evident how the patients, and where appropriate their carers, are involved in the process, if at all, or if they are provided an opportunity to receive a copy of either their risk screen or recovery plan.

6.61 The support that Mr S was offered by both statutory and drug and alcohol services, from January 2013, was episodic and mainly in response to crisis situations. There was no consistent long-term involvement of any agency, which led to a fragmented understanding of Mr S's presenting issues, his life experiences and their effects on his mental health and alcohol dependency.

6.62 During the course of our investigation, there were several significant interrelated factors that we felt required further exploration and understanding: these were the psychosocial needs and treatment of refugees, especially those with PTSD and alcohol dependency. We have looked to NICE guidelines from 2005 – Post-traumatic stress disorder (PTSD): The management of PTSD in adults and children in primary and secondary care[182] – that were in place at the time. Additionally, in order to be able to situate and understand Mr S's individual issues within the context of his particular personal history, we have undertaken a review of various research papers

[180] GP notes, 9 May 2013

[181] Somerset Partnership NHS Foundation Trust, Clinical Assessment and Management of Risk of Harm to Self and Others Policy, August 2012, p5

[182] NICE guidelines (CG26) March 2005, Post Traumatic Stress Disorder http://pathways.nice.org.uk/pathways/post-traumatic-stressdisorder

relating to the complex mental health and psychosocial problems that arose during the civil war in Sri Lanka.

6.63 All the agencies involved in supporting Mr S were documenting that they were aware that Mr S was suffering from PTSD. The treatment plan was that he was to be referred to specialist psychological therapy once he had achieved and was able to sustain abstinence from alcohol. This is in line with the NICE guidance with regard to comorbidities in PTSD, such as alcohol dependency and depression. The guidelines state that "for PTSD sufferers with drug or alcohol dependence or in whom alcohol or drug use may significantly interfere with effective treatment, healthcare professionals should treat the drug or alcohol problem first."[183]

6.64 What we have ascertained from our review of the police's records is that within 24 hours of Mr S being discharged from his detox programme, he was drinking to excess, and from this point he was not engaging with services except in crisis situations.

6.65 The challenges that agencies faced in their ongoing management of Mr S are clearly identified within the NICE guidelines that advises:

- "Healthcare professionals should be aware that many PTSD sufferers are anxious about and can avoid engaging in treatment. Healthcare professionals should also recognise the challenges that this presents and respond appropriately, for example, by following up PTSD sufferers who miss scheduled appointments.

- For PTSD sufferers whose assessment identifies a high risk of suicide or harm to others, healthcare professionals should first concentrate on management of this risk.

- Healthcare professionals should pay particular attention to the identification of individuals with PTSD where the culture of the working or living environment is resistant to recognition of the psychological consequences of trauma."[184]

6.66 NICE guidance for drug treatment for patients with PTSD recommends that:

- "Drug treatments (paroxetine or mirtazapine for general use and amitriptyline or phenelzine for initiation only by mental health specialists) for PTSD should be considered as an adjunct to psychological treatment in adults where there is significant comorbid depression or severe hyperarousal that significantly impacts on a sufferer's ability to benefit from psychological treatment."[185]

[183] NICE guidelines (CG26) March 2005, Post Traumatic Stress Disorder http://pathways.nice.org.uk/pathways/post-traumatic-stressdisorder

[184] NICE guidelines (CG26) March 2005, Post Traumatic Stress Disorder http://pathways.nice.org.uk/pathways/post-traumatic-stressdisorder

[185] NICE guidelines (CG26) March 2005, Post Traumatic Stress Disorder http://pathways.nice.org.uk/pathways/post-traumatic-stressdisorder

6.67 This was the drug regime that Mr S was prescribed. However, the following guidelines regarding the management of such a medication regime in patients such as Mr S were not followed:

- "Adult PTSD sufferers started on antidepressants who are considered to present an increased suicide risk and all patients aged between 18 and 29 years (because of the potential increased risk of suicidal thoughts associated with the use of antidepressants in this age group) should normally be seen after 1 week and frequently thereafter until the risk is no longer considered significant.

- Particularly in the initial stages of SSRI treatment, practitioners should actively seek out signs of akathisia, suicidal ideation, and increased anxiety and agitation. They should also advise PTSD sufferers of the risk of these symptoms in the early stages of treatment and advise them to seek help promptly if these are at all distressing."[186]

6.68 In our review of Mr S's notes, it was clearly apparent that these guidelines were not consistently being followed, as the practitioners were systematically failing to adequately and consistently identify and consider Mr S's high level of risk of suicide.

6.69 The NICE guidance highlights the importance of healthcare professionals providing patients with "information about common reactions to traumatic events, including the symptoms of PTSD and its course and treatment … Healthcare professionals should consider offering help or advice to PTSD sufferers or relevant others on how continuing threats related to the traumatic event may be alleviated or removed."[187] Apart from very superficial enquiries made to Mr S about his childhood experiences, we found no evidence that any agency was discussing with Mr S the possible connections between his current issues, including his alcohol dependency, his depression and his traumatic experiences as a child and young man.

6.70 Apart from two clinicians who had direct personal knowledge of Sri Lanka and its complex political and social history, we found that although it was consistently being identified that Mr S had PTSD, practitioners who were assessing and supporting Mr S appeared to only have a slight knowledge of the context of Mr S's history. We asked about the ethnic profile of patients in what is a predominately rural area and were informed that in the main the minority ethnic groups were from Eastern Europe. Although it is clear that anyone can suffer from PTSD and may have similar presentations of symptoms, NICE guidelines directs that "Where a PTSD sufferer has a different cultural or ethnic background from that of the healthcare professionals who are providing care, the healthcare professionals should

[186] NICE guidelines (CG26) March 2005, Post Traumatic Stress Disorder http://pathways.nice.org.uk/pathways/post-traumatic-stressdisorder

[187] NICE guidelines (CG26) March 2005, Post Traumatic Stress Disorder http://pathways.nice.org.uk/pathways/post-traumatic-stressdisorder

familiarise themselves with the cultural background of the PTSD sufferer."[188] We found no evidence to indicate that practitioners were researching information about areas such as the conflict in Sri Lanka and the particular issues that refugees from this conflict may be facing as refugees in the UK.

6.71 When Mr S did disclose information about his history, no agency appeared to take the opportunity to open up a discourse with him about his history and experiences or to identify particular cultural support needs he may have had as a refugee. NICE repeatedly recommends the use of interpreters and bicultural therapists, but there was no evidence of any occasion when this was being considered or discussed with Mr S.

6.72 Clearly we recognise that addressing such issues with a patient as vulnerable as Mr S is without doubt complex and must be approached with a great deal of sensitivity. We did feel that without exception all agencies remained primarily focused on crisis intervention and on Mr S's alcohol dependency and required abstinence rather than looking at these issues within a wider context. There was also no indication that any practitioner was considering the possibility that Mr S's abstinence was likely to repeatedly fail until he was supported to at least begin to resolve the underlying root causes. Although NICE's guidelines do recommend that a patient's drug or alcohol problem should be the primary treatment focus, given Mr S's profound multiple and complex issues we would suggest that consideration perhaps should have been given to attempting to engage him with some form of PTSD psychological therapy.

6.73 The NICE guidance directs that "all PTSD sufferers who are prescribed antidepressants should be informed, at the time that treatment is initiated, of potential side effects and discontinuation/withdrawal symptoms"[189] (particularly with paroxetine). We could see no documented evidence to indicate that Mr S had been given advice regarding his medication and the potential side effects both in terms of whilst he was taking the medication and if he discontinued. Indeed, the potential risks of him discontinuing his medication or drinking excessively whilst taking it were not considered within any assessment.

6.74 With regard to the inter-agency management of Mr S's care, NICE's guidelines clearly directs that:

- "Where management is shared between primary and secondary care, there should be clear agreement among individual healthcare professionals about the responsibility for monitoring patients with PTSD. This agreement should be in writing (where appropriate, using the Care Programme Approach [CPA]) and should be shared with the patient and, where appropriate, their family and carers.

[188] NICE guidelines (CG26) March 2005, Post Traumatic Stress Disorder http://pathways.nice.org.uk/pathways/post-traumatic-stressdisorder

[189] NICE guidelines (CG26) March 2005, Post Traumatic Stress Disorder http://pathways.nice.org.uk/pathways/post-traumatic-stressdisorder

- Patient preference should be an important determinant of the choice among effective treatments. PTSD sufferers should be given sufficient information about the nature of these treatments to make an informed choice."[190]

6.75 Clearly in the management of Mr S's case this type of inter-agency management plan did not occur, and, as we have already identified, his care was fragmented, there was little information sharing and there was no practitioner identified as the care coordinator.

6.76 Given the issues that we have identified in relation to both working with a patient with such complex cultural and psychological needs and the fact that the relevant NICE guidelines were not in the main followed, we concluded that both Somerset Partnership NHS Foundation Trust and the recommissioned Somerset Drug and Alcohol Service (SDAS) need to consider developing a specific policy for the provision of services, which includes both psychological and social needs, to refugees that includes NICE's guidelines on managing patients with PTSD. The primary care service also need to familiarise themselves with NICE's guidelines regarding the provision of care to this particular patient group.

6.77 We would also suggest that in addition to ensuring that all Somerset Partnership NHS Foundation Trust's policies include issues regarding the provision of culturally aware services, a specific policy is developed for the provision of services to refugees. Such a policy should include guidance with regard to refugees' psychological, social and physical health needs as well as the recommendations from the relevant NICE guidelines. A training programme should be introduced alongside the launch of such a policy. This will both facilitate an improvement to provision to patients from ethnic minorities and develop and improve practitioners' knowledge with regard to the relevant NICE guidelines.

Somerset Primary NHS Foundation Trust and Somerset Drug and Alcohol Service:

Recommendation 5:

Both Somerset Partnership NHS Foundation Trust and the recommissioned Somerset Drug and Alcohol Service (SDAS) need to consider developing a specific policy, which includes consideration of the psychological, accommodation and social needs in the provision of services to refugees. Such a policy should include NICE's guidelines on supporting such patients with PTSD.

[190] NICE guidelines (CG26) March 2005, Post Traumatic Stress Disorder http://pathways.nice.org.uk/pathways/post-traumatic-stressdisorder

Primary Care Service:

Recommendation 6:

The primary care service involved in this case should familiarise themselves with NICE's guidelines regarding the provision of health care to refugee patients.

Somerset Partnership NHS Foundation Trust :

Recommendation 7:

Somerset Partnership NHS Foundation Trust's Risk Assessments and Recovery Care Plans should have a section to indicate if a patient has been involved in the process. The form should also indicate if a patient has agreed with the assessment and if not it should be documented what are their reasons. Also the assessment and plan should indicate if the patient has been asked if they would like a copy.

7 Mr S's relationship with Ms G and her partner

7.1 As Mr S declined to take part in this investigation, we have only been able to ascertain information regarding the nature of the relationship between the parties from the police's interview with Ms G's partner after the incident.

7.2 Ms G's partner reported that when he came to the UK a friend from Sri Lanka gave him Mr S's contact details and he first met Mr S in 2010 in London. He reported that he was not aware of what region in Sri Lanka Mr S came from.

7.3 Ms G's partner reported that he initially moved to Somerset in 2010 where he had some telephone contact with Mr S "when he was drunk."[191] He then moved to Cardiff where he first met Ms G. He reported that as she did not speak much English, he began to interpret for her and then their relationship began. Ms G then moved to Nottingham and in July 2012 Mr S invited Ms G and her partner to come and live with him in Somerset.

7.4 Ms G's partner reported that Ms G would cook and look after Mr S "like her own brother"[192] but soon after they began living together Mr S "started to be nasty"[193] to Ms G. He recalled one incident in July 2012 when Ms G arrived at his place of work and was upset. She said that she had been in the lounge when Mr S came and sat on her lap, trying to get close to her and kiss her.

[191] Police interview, 20 August 2013, p3

[192] Police interview, 20 August 2013, p4

[193] Police interview, 20 August 2013, p4

She said that he was drunk and she had pushed him away, saying, “Why do you do this to me you… are like a brother and I am like a sister.”[194] Ms G and her partner decided that they had to move and gave Mr S three months’ notice.

7.5 Ms G’s partner reported that Mr S was continually getting drunk and that they had several physical confrontations. On one occasion Mr S placed his hands around Ms G’s partner’s neck. They did not report most of these incidents to the police. Ms G’s partner reported that they began to lock their bedroom door as they were afraid of Mr S.

7.6 Ms G’s partner went on to report in his interview that Mr S “knew things that would upset me. I told him not to say these things, but I could say the same to him about his mum, he then attacked me by punching me in the head and putting his hands around my neck.”[195] He reported sustaining some minor scratches.

7.7 Mr S reported to the author of the SIR[196] that he had known both Ms G and her partner in Sri Lanka and that he had “treated the girl as a little sister.”[197] Mr S also reported that during the trial Ms G’s partner’s denial that either he or Ms G had known him was “upsetting as he’d provided them with considerable practical help when they first came to England.”[198]

7.8 When Ms G and her partner moved out, it was reported that there were ongoing difficulties with Mr S and that he would arrive at their accommodation uninvited. Ms G’s partner reported that on these occasions he had wanted to call the police but Ms G would say: “Don’t worry he’s drunk, by the time the Police come he will have vanished.”[199]

7.9 Ms G’s partner reported that Ms G “would not open the door as she was scared”[200] and that he had advised her to put the security chain on the door and not open it unless she knew who it was and that she should keep the front door key under her pillow. Ms G’s partner reported that sometimes Mr S would use a different voice so that she would be tricked into opening the door. He also reported that because of their ongoing fears about Mr S they had made plans to relocate. The police reported that when they entered Ms G’s flat on the day of the incident they had found a number of packed suitcases, which indicated that their move was imminent.

[194] Police interview, 20 August 2013, p4

[195] Police interview, 20 August 2013, p10

[196] Interview took place after Mr S’s trial, 17 November 2014

[197] SIR interview, p2

[198] SIR interview, p2

[199] Police interview, 20 August 2013, p15

[200] Police interview, 20 August 2013, p15

8 Employment

8.1 Mr S reported[201] that as a young man in Sri Lanka he had been working "odd jobs"[202] which involved mobile phones, but the exact nature of this employment is unclear.

8.2 The one restriction of Mr S's visa, when he initially arrived in the UK, was that he was not permitted to work. Mr S reported to his GP in Scotland (17 September 2008) that he was working "for a friend although not officially allowed to."[203] This was during the period when he was applying for refugee status.

8.3 When Mr S initially moved to the Somerset area, he was working in a petrol station until 1 February 2013, when he was made redundant. He was then employed in a supermarket but was reportedly given notice due to his drinking.

8.4 At the time of the incident Mr S was not working and was in receipt of benefits.

8.5 On the day of the incident, Mr S is reported to have told a friend that the Job Centre were only able to offer him part-time work, so he was thinking about moving in order to secure full-time employment.

9 Housing

9.1 During an assessment in A & E (29 January 2013), Mr S reported that he was going to be evicted at the end of the month, and he also alluded to the fact that he was experiencing ongoing difficulties with his flatmates. The assessor noted that "it is unclear whether (Mr S) is experiencing paranoid beliefs or whether he is in fact vulnerable from physical and psychological harm from his flat mates."[204]

9.2 An accommodation assessment that was completed by a member of the CRHT when Mr S was initially assessed in A & E documented that he was living in "no settled accommodation."

9.3 The CRHT assessor concluded that "should (Mr S) have a secure supportive home environment I would have been inclined to offer intensive home treatment from the crisis resolution and home treatment team. However this is not the case and in fact (Mr S) named the main stressor as his house mates."[205]

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[201] Psychiatric assessment 2013

[202] Interview with inpatient consultant

[203] GP notes, 19 September 2008

[204] Risk Information, 29 January 2013

[205] Risk Information, 29 January 2013

9.4 During CRHT's first meeting with Mr S, where he disclosed that he was to become unemployed and homeless, the CRHT noted that Mr S continued to drink alcohol, which was identified as a problem along with his housing issues and debt. The CRHT documented that they had advised Mr S to attend the housing department in order for him to resolve his housing issues.

9.5 On 14 February 2013 Mr S moved into temporary bed-and-breakfast accommodation. On 27 February 2013 he moved into a social housing unit which was in close proximity to where Ms G and her partner lived.

Arising issues, comments and analysis

9.6 We noted that only one accommodation assessment was completed, although the issue of Mr S's housing was being identified by the CRHT and CAAS as a significant contributory factor in Mr S's recent mental health crisis and increased alcohol consumption. Mr S was being advised to contact the housing department. We question if it was reasonable to have expected a person such as Mr S, who was experiencing acute mental health and alcohol dependency issues and whose first language was not English, to be able to negotiate the complexities of applying for social housing.

9.7 As far as we have been able to ascertain, there was no liaison between secondary mental health services and the housing department. There is also no indication to suggest that the housing department were aware of the allegations of harassment. Their allocation of a property to Mr S in February 2013 was based on his acute housing need, in order to move him out of temporary accommodation to more secure social housing.

9.8 Based on the evidence that we obtained, there was no indication that after Mr S's move to housing that was in close proximity to Ms G and her partner, the harassment or his contact with them escalated to any great extent. Indeed, many of the incidents of harassment occurred at either Ms G or her partners' place of work. Ms G's partner reported[206] that in April or May 2013 Mr S went to Ms G's place of work where he became verbally abusive; she was very distressed by the incident and subsequently left her employment.

9.9 From the information we have obtained, it is evident that after Mr S arrived in the UK he moved both locations and accommodation on numerous occasions. On arrival in Scotland he was initially living in a refugee hostel, and it appears that when he moved to the Somerset area, on at least one occasion his accommodation was provided by his employer. This meant that when he lost his employment he then lost his accommodation. He also appeared to live in several private rental properties, which meant that Mr S was facing high rents and insecure tenancies.

9.10 In our opinion, Mr S's ongoing difficulties in obtaining appropriate, affordable and secure housing left him vulnerable in terms of his housing needs and would have also exacerbated his unstable, isolated and nomadic existence. It also meant that each of Mr S's moves required a change of primary services;

[206] Police interview

therefore, no one service was able to either develop a relationship with Mr S or obtain an in-depth understanding of his mental health needs.

9.11 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.[207] Securing and maintaining appropriate housing is identified within the Department of Health's strategy 'No health without mental health'.[208] 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."[209] Research[210] 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."[211]

Recommendation 8:

Somerset Partnership NHS Foundation Trust;

Risk Assessments and Recovery Support plans should always identify and consider 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 and support.

[207] 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

[208] 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

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

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

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

10 Drug and Alcohol Service

10.1 As part of this investigation, we interviewed the Senior Operations Manager and Acting Hub Manager [212] from agency 1, we also had accessed to Mr S's notes.

10.2 We were informed that in February 2014 drug and alcohol services within Somerset were recommissioned by the local authority and the Clinical Commissioning Group (CCG). The new service configuration is known as Somerset Drug and Alcohol Service (SDAS) and is provided by three organisations: agency 1, the Crime Reduction Initiative (CRI) and the Direct Homeless Initiative (DHI). Representatives from the police and secondary mental health services as well as commissioners sit on SDAS's Board, which is convened on a quarterly basis. There are also monthly meetings between the three partner service providers, and performance and governance issues are reviewed at this meeting.

10.3 Agency 1 reported to us that this was a new structure and that they were also in the process of implementing a new clinical governance framework for their service.

10.4 Agency 1 reported that as far as they were aware, they did not undertake an internal investigation after this incident, as Mr S was not under their treatment programme at the time of this incident. Although it was thought that they did write a report for Somerset Partnership NHS Foundation Trust's SIR, they had not received any feedback on the report.

10.5 Since the incident, mental health, alcohol services and other providers have been developing a dual diagnosis pathway, which includes joint assessments, care planning and reviews. Where a service user is assessed as having a severe or enduring mental health issues, the assessor would discuss it at the team meeting and/or with the supervisor, where it would be agreed where to refer them in order to maximise their chance of addressing and achieving their goals around alcohol use. Referrals would be to either IAPT[213] or straight community mental health services.

10.6 It was also reported to us that in 2014 the CCG required that all the partner organisations adopt Halo as their record system. One of the improvements that this integrated system has allowed is that one risk assessment can be utilised by all agencies using this system. This enables one assessment to be developed and amended throughout the lifetime of a patient's treatment programme.

10.7 With regard to information sharing between secondary mental health services and SDAS, we were informed that there is not a formalised arrangement

[212] Who community detox nurse at the time Mr S was being treated by agency 1

[213] IAPT: Improving Access to Psychological Therapies

regarding sharing information and that it is done on a "*case by case basis*."[214] It is practitioner led rather than process led.

10.8 It was reported to us that there are issues regarding the quality and content of risk assessment forms that they are still in the process of resolving with the CCG. We were also informed that Halo is not compatible with the Trust's RiO patient records system.

> Recommendation 9:
>
> Somerset Drug and Alcohol Service (SDAS) and Somerset Partnership NHS Foundation Trust must agree a formal information-sharing protocol.

11 Contact with the police

11.1 From January 2013 to the incident, Mr S had contact with Avon and Somerset Police on 25 separate occasions. On several occasions Mr S made numerous calls to the police via 999 on the same day (see chronology appendix c).

11.2 There were repeated instances when Mr S reported that he had been attacked, harassed or was being poisoned by Ms G and her partner. At other times he reported that he had been racially abused by members of the public or that he wanted to go back to Sri Lanka.

11.3 Ms G's partner also made repeated calls to the police, reporting that Mr S was trying to gain access to their accommodation, was physically attacking him, was stalking both himself and Ms G at their place of work and accommodation and was making repeated abusive calls to him.

11.4 During one call (23 January 2013) to the police, Mr S alleged that Ms G was calling him 40 to 50 times a day. During the police's investigation they did find evidence of some mobile phone contact between Ms G and Mr S and that this appeared to take place whilst Ms G's partner was at work.

11.5 There were several occasions when police officers arrived during physical altercations between Mr S and Ms G's partner. Both refused to make a formal complaint and the police managed the situation on several occasions by utilising the restorative justice process.[215]

11.6 More often than not, when Mr S made contact with the police he was intoxicated and at times abusive to the police call handlers and the attending officers.

[214] Interview with Senior Operations and the Manager from agency 1

[215] The restorative justice process requires that both parties meet and agree to the process. Requires an apology for the behaviour or actions or reparation of any loss or damage

11.7 Following several incidents where police had been called out to incidents involving Mr S and Ms G's partner, the attending police officer completed an Anti-Social Behaviour (ASB) form.[216] This classified the incidents as 'nuisance'. As part of the initial ASB assessment, there were several failed attempts to contact Mr S to assess his risk towards others (24 and 26 January 2013). A letter was then sent to Mr S, but he failed to respond. No further action was taken; although the ASB was updated on several further occasions following incidents involving Mr S (refer to chronology in appendix c).

11.8 There was one incident involving the police where Mr S was in possession of a weapon: on 7 February 2013 a witness reported to the police that during an argument between Mr S and Ms G's partner, she had taken a kitchen knife off Mr S.

11.9 On 31 May 2013 police were called to a public order incident where Mr S was in possession of an iron bar. Mr S was initially arrested for wounding with intent; however, subsequent police enquiries revealed that Mr S had actually been the victim in this incident and that he had been trying to disarm the other individuals. There were also several incidents when police were called to public order disturbances involving Mr S. On 6 March 2013 Mr S was arrested for being drunk and disorderly outside a supermarket. He claimed that he was being racially abused by the security guards.

11.10 On 11 July 2013 Ms G's partner contacted the police, reporting that Mr S was trying to gain access to their accommodation. During the subsequent police investigation, police deleted Ms G's partner's contact details from Mr S's mobile phone and advised him that any further incidents could lead to his arrest, which could affect his visa. This was the last contact the police had with either Mr S, Ms G or her partner until the incident itself (6 August 2013).

Arising issues, comments and analysis

Following this incident the IPCC undertook a review of Avon and Somerset Police Authority's involvement. Although we had sight of this report it has yet to be published, so we are unable to comment on its findings. However, based on the information that we obtained directly from Avon and Somerset Police, we have the following comments to make:

11.11 With the exception of the incident on 20 June 2013[217] Ms G did not have direct contact with the police; all the other incidents in which she was involved were being reported by her partner. Ms G's partner explained in his police interview after the incident that the reason for her reluctance to speak to the

[216] Anti-Social Behaviour (ASB) forms record details of the event and allow for repeated problems with locations or an individual to be monitored for events

[217] Contact was via telephone as police were trying to gain access to her accommodation, as her partner had reported that Mr S was attempting to break into the property

police was that in Sri Lanka "the police are not trusted particularly by women and that to be seen with police in attendance was an embarrassment."[218]

11.12 From the evidence that we have been able to obtain, there were no reported incidents where Mr S was directly physically aggressive towards Ms G. However, whilst they were all living together there were several reported incidents of intimidation. These incidents were not being categorised as domestic violence (DV) by the attending officers, as Avon and Somerset Police's Domestic Abuse Policy defines a DV incident as: "Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between people aged 16 or over, who are or have been intimate partners or family members, regardless of gender and sexuality."[219] Although Ms G was living in the same domestic situation as Mr S, the relationship between Mr S and Ms G did not fall within the prescribed category of being at risk of DV, and therefore incidents were not identified as potential incidents of DV. Through the course of this investigation, we have become aware that there was a complex interpersonal relationship between all the parties. If this had been known at the time, the incidents may have fallen within the DV category and as such Ms G may have been identified by the police as a vulnerable adult.

11.13 With regard to the police's knowledge and responses to Mr S's mental health issues, from January 2013 there were numerous occasions (see chronology in appendix c) where police noted that Mr S had ongoing mental health issues. There were also several incidents when he reported to both the police call handlers and officers that he had either taken an overdose or was expressing suicidal thoughts. There were several occasions when police did liaise with mental health services: on 1 April 2013 the attending police officers contacted the inpatient unit to discuss what help was available to Mr S, and when Mr S was arrested (7 March 2013) the custody sergeant referred him to the CAAS, as he had some concerns about his presentation.

11.14 Our access to police records has shown that Mr S's repeated contacts with the police were unknown to either primary or secondary mental health services. It also revealed that the day after Mr S was discharged from the inpatient unit where he had undergone a detox programme, he was drinking again.

11.15 The majority of the police's contacts with Mr S were challenging, as he was often obstructive and intoxicated. During our review of the police records, it appeared to us that in the majority of incidents police perceived that Mr S was the instigator of the incidents. Alcohol was identified as the underlying causal factor in his behaviours and presentation, rather than any mental health issues or consideration that Mr S was a vulnerable adult and the victim of abuse or harassment.

[218] Police interview

[219] Avon and Somerset Domestic Abuse Policy

11.16 Additionally, although police officers and call handlers often had previous knowledge of Mr S available to them, via police records, ABS forms and officers having attended previous incidents, the various crisis situations were in effect being managed in isolation. There was no evidence that the police, or indeed any other agency which had ongoing involvement with Mr S, considered the need to instigate a coordinated multi-agency approach in relation both to information sharing and to the assessment and provision of support to Mr S.

12 Post-incident Serious Untoward Incident Review (SIR)

12.1 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*."[220]

12.2 We benchmarked Somerset Partnership NHS Foundation Trust's Level 2 Serious Incident Review (SIR), utilising the National Patient Safety Agency's RCA Investigation Evaluation Checklist.[221]

12.3 Following the incident, Somerset Partnership NHS Foundation Trust commissioned a Root Cause Analysis investigation *"to establish the full facts and sequence of events and identify the contributory factors and to identify and share learning points in order to reduce the risk of similar future adverse events*."[222]

12.4 The SIR was conducted by a staff member of Somerset Partnership NHS Foundation Trust.

12.5 We were unable to interview the author of the SIR as he has since retired, but we did have access to the interview notes.

Arising issues, comments and analysis

12.6 We concluded that the SIR provided a comprehensive chronology of and commentary on circumstances that led up to the incident and the various agencies' involvement.

12.7 An extensive review of both RiO notes and relevant Trust policies that were operating at the time was also undertaken by the author of the SIR.

12.8 One of the recommendations made by the author of the SIR was that when Mr S's trial concluded, a representative from Somerset Partnership NHS Foundation Trust was to arrange to meet with Mr S, Ms G's partner and two of Mr S's friends who accompanied him at an A & E admission. There is no

[220] TOR Appendix B

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

[222] SIR, p5

evidence if this occurred or what efforts the Trust made to locate these individuals.

12.9 As we have already noted NHS England had been unable to locate Ms G's partner to inform him that an investigation had been commissioned and to invite him to contribute to its Terms of Reference. We were informed by the police that it was their understanding that he had moved out of the area and they did not have a forwarding address.

12.10 The author of the SIR did interview Mr S on 17 November 2014.

12.11 There are several issues within the SIR that we would like to draw the Trust's attention to in order to improve future SI investigations. Although the author concluded that the events that led to the death of Ms G were not predictable, it failed to consider the preventability of the incident.

12.12 Additionally, although the SIR did identify that Mr S was a Sri Lankan national, it failed to consider his cultural needs or comment on whether the SIR author believed that services were providing him with culturally sensitive support.

12.13 Although it was alluded to, we felt that the SIR author did not adequately consider the possible psychological effects and the possible connection between Mr S's alcohol dependency and his childhood experiences as well as the fact that he was a victim of torture and a refugee. All of these issues we have concluded were significant in terms of his presentation and therefore were fundamental in the understanding of Mr S's relationship with services, his risk towards himself and others, and the events that led up to Ms G's death.

12.14 The author of the SIR referred to NICE guidance on Alcohol Use Disorder and its Clinical Guidelines for Depression, but did not make reference to NICE's Post-traumatic stress disorder (PTSD): The management of PTSD in adults and children in primary and secondary care (March 2005). We would suggest that it would have been helpful to have both understood and situated Mr S's PTSD and alcohol dependency within the context of the events in his personal history. It would also have enabled the author to evaluate the assessments that were undertaken and also the support being offered to Mr S by the Trust in light of NICE guidelines.

12.15 The SIR's author concluded it was "inappropriate"[223] to invite anyone from his social network or Ms G's family to be involved in the SIR. We do not agree with this decision, as we feel that they might have been able to provide additional and valuable insight that would have helped to develop a more comprehensive profile of Mr S and of the events that led up to the incident itself.

12.16 The methodology utilised by the author of the SIR was Root Cause Analysis. However, we saw no evidence of this methodology within the report, for

[223] SIR, p29

example a fishbone diagram.[224] Inclusion of such an investigative aid would have assisted the reader to focus on the causal factors.

Recommendation 10:

Authors of Serious Incident Reports must include evidence within their reports of the methodology that is being utilised within their investigations, for example Root Cause Analysis, a fishbone diagram, 5 Whys.

Recommendation 11:
Authors of Serious Incident Reports must ensure that they are referring to all the relevant NICE guidelines that were in place at the time of the incident.

13 Trust progress in the implementation of the internal recommendations

13.1 Somerset Partnership was authorised as a Foundation Trust on 1 May 2008. It currently provides a wide range of integrated community health, mental health, learning disability and social care services. The Trust employs more than 4,000 staff, and has a turnover of £158 million.[225] At the time of the incident (2013), the Trust's six strategic aims were: "Viability and Growth, Culture and People, Integration, Innovation, Quality and Safety and Service Delivery."[226]

13.2 In order to review and evaluate Somerset Partnership NHS Foundation Trust's progress on the implementation of the action plan that arose from Mr S's SIR, we interviewed the Medical Director, Director of Governance and Corporate Development, and Head of the Adult Mental Health Inpatient and Assessment Division.

13.3 We also undertook a review of the relevant policies that were operating at the time as well as those that have been subsequently reviewed.

13.4 During the course of our investigation, we obtained two action plans relating to this case by the Trust. As the action plans were not dated, it was difficult for us to have a sense of their chronology and also different report proformas were being utilised, so again we had some difficulty cross-referencing them. We would suggest that in future the Trust's should adopt a universal action

[224] A fishbone diagram is a visual way to look at cause and effect. Can help in brainstorming to identify possible causes of a problem and in sorting ideas into useful categories

[225] http://www.sompar.nhs.uk/who-we-are/

[226] Somerset Partnership NHS Foundation Trust's Annual Report 2013/14, p4

plan proforma and that the relevant STEIS incident number is clearly documented.

13.5 However, based on their contents, it appears that action plan 1 was completed post SIR while the second was updated in January 2015, which was post Mr S's trial.

13.6 Action plan 1 directly relates to the four recommendations from the SIR report. It was only partially completed; for example the sections regarding evidence and 'how and to whom have the lessons learnt relating to the action been disseminated' were not completed and the actions identified were not SMART.[227] All the recommendations had update reports and three were reported to have been completed. The action relating to the clarification of the role of care coordinator in the CRHT and CAAS services identified that "this will be taken forward through the Phase 2 integrated project."[228] It was reported to us that the aim of Phase 2 "is to make the patient pathway seamless both physical and mental health services would wrap around the patient as required … we are trying to build in an efficiency but also to improve the way in which services adjust to patients, so that the patient gets a better pathway through the service."[229]

13.7 This second action plan has only one recommendation: "to consider meeting the people named in the report with a view to understanding the situation and mental health services prior to the incident."[230] The timescale for this was identified as "dependent on trial." There was a subsequent entry, dated January 2015, which notes: "outcome of trial in March 2014 was life sentence with a minimum of 18 years. Due to the length of time from the incident and outcome of the trial the decision was made that a meeting would not be appropriate however the Head of Division would be happy to meet with people named in the report if they request a meeting."[231] We noted that there was no action documented regarding how and who was responsible for alerting the relevant people of this facility, and this was not identified by either the SIR or the first action plan.

13.8 Since this incident, the Local Authority Safeguarding Adults Multi Agency Policy has been revised (August 2014), as has Somerset Partnership NHS Foundation Trust's Safeguarding Adults at Risk Policy (August 2015). The latter notes that "an adult at risk's vulnerability is influenced by a range of interconnected factors including personal characteristics, factors associated with their situation or environment and social factors."[232] We would suggest that in light of the findings of this report, which identified the cultural influences

[227] SMART: Specific, Measurable, Achievable, Realistic and Time bound

[228] Action plan 1, p2

[229] Interview with Medical Director, Director of Governance and Corporate Development

[230] Local Action Plan, p1

[231] Local Action Plan, p1

[232] Somerset Partnership NHS Foundation Trust's Safeguarding Adults at Risk Policy, August 2015, p10

that resulted in both Mr S and Ms G being extremely vulnerable individuals, the policy should also direct that consideration should be given to an individual's culture and ethnicity. As both are significant and interconnecting factors to these particular patients' ongoing vulnerabilities and risks of being abused.

Arising issues, comments and analysis

13.9 We noted that neither the SIR nor the subsequent action plans identified the need to offer feedback to either Ms G's family or her partner.

13.10 We had extensive discussions with the Trust's Medical Director and Director of Governance and Corporate Development about the process, the quality of this particular action plan and the subsequent monitoring processes. It was reported to us that the process is that the Trust's Head of Risk has the responsibility for reviewing an SIR report's recommendations, and then the relevant service lead would develop an action plan that is relevant to their particular service. The action plan would identify the lead's title rather than a named person responsible for each action. This would be overseen and monitored by the Head of Risks and the SIRI Review group to the point of completion. It is then reported to the clinical governance group and integrated governance committee. Learning from SIR reports, at both a wider Trust and at a local service and team level, is cascaded through Heads of Division and local managers who attend the SIR meetings and where relevant via staff newsletter.

13.11 It was acknowledged to us that both the action plan and the monitoring of this particular SIR report were not as robust as they should have been, and it was suggested that this was due in part to the fact that there is "often the long timescale between the event, the investigation and then the action plan and there is a loss of momentum."[233] It was reported that the SIRI group often has to review several serious and significant SIR reports within a very limited time frame.

13.12 It was reported to us that it was unclear if Mr S's SIR and the subsequent action plan had been monitored by the SIRI group[234]. The reasons given to us for the failure to monitor these action plans were unclear but we were reassured that the restructuring that has taken place since this incident, in relation to the monitoring of SIR action plans, were robust and that it was unlikely that this could occur again. However we would suggest that in order to ascertain the progress on the implementation of the Mr S's action plan Somerset Partnership NHS Foundation Trust should consider undertaking an audit exercise to ensure that all actions have now been fully implemented.

[233] Interview with the Trust's Medical Director and Director of Governance and Corporate Development

[234] SIRI Serious Incident Requiring Investigation Review Group

13.13 It was also reported to us that since this incident, the Trust has undergone significant changes in terms of both its service delivery and its governance structures. These are:

- The introduction of physical health checks on admission, including for patients with psychosis or particular long-term conditions, and speciality doctors are involved in a patient's physical health care. The intention of this is to develop seamless patient pathways where both physical and mental health services would "*wrap*"[235] around the patient as required.

- After an inpatient detox admission, a patient with mental health issues will be discharged to drug and alcohol services as well as being allocated a community consultant psychiatrist. It will be a "dual-based discharge."[236]

- Although the Trust and local authority use different IT records systems, there is a now a facility that allows both agencies to access a "*snap shot view*"[237] of the other agency's records. This allows for a person's significant risk and support need information to be shared between agencies. It was reported however that currently agency 1 does not have access to this facility. It was reported to us that this is part of a longer-term strategy to make secondary heath care and agency 1 record systems compatible so that information can be accessed by both agencies.

13.14 When we asked one senior manager what care pathways would now be available to a patient with similar risks and support needs as Mr S, it was reported that given his presentation and reluctance to engage with services, the care pathway available would probably not be different. It was reported to us that what have changed are the systems that are now in place to facilitate inter-agency information sharing. We would suggest that in order to evaluate the effectiveness of these new information-sharing systems, Somerset Partnership NHS Foundation Trust should undertake an audit of a number of cases involving similar complex patients where there is both internal multi-service and external multi-agency involvement.

Recommendation 12:

Somerset Partnership NHS Foundation Trust:

The Safeguarding Adults at Risk Policy should direct practitioners to consider a patient's culture and ethnicity as being significant and interconnecting factors to both their vulnerabilities and their potential risks of being abused.

[235] Interview with the Trust's Medical Director and Director of Governance and Corporate Development

[236] Interview with the Trust's Medical Director and Director of Governance and Corporate Development

[237] Interview with the Trust's Medical Director and Director of Governance and Corporate Development

Recommendation 13:

Somerset Partnership NHS Foundation Trust should adopt a universal action plan proforma and ensure that the relevant STEIS incident number is clearly documented on the original and on subsequent action plans.

Recommendation 14:

In order to ensure that all the action plans that have arisen out of this Serious Incident Report have been fully implemented, Somerset Partnership NHS Foundation Trust should undertake an immediate audit of each recommendation.

Recommendation 15:

In order to evaluate the effectiveness of the new information-sharing systems introduced since this incident, Somerset Partnership NHS Foundation Trust should consider undertaking an audit exercise of a number of cases, involving similar complex patients, where there is both internal and external multi-agency involvement.

14 Predictability and preventability

14.1 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 should consider if the incident which resulted in the death of Ms G was either predictable[238] or preventable.[239] 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."[240]

14.2 A significant amount of information regarding Mr S's historical and recent psychosocial background has only come to light during the course of this investigative process, as we have been able to access primary care notes as well as review Mr S's Border Agency file. In addition, we have had access to the IPCC report[241] as well as some of their PNC[242] records. None of these sources of information were available to either the primary and secondary health care services who were supporting Mr S or the author of the SIR report. This benefit of hindsight[243] has been extremely useful to us, as it has assisted us in developing a comprehensive profile of both Mr S and the events that led up to the incident itself which resulted in the death of Ms G.

Predictability

14.3 The extensive professional knowledge of the advisory panel has greatly assisted in developing an understanding of Sri Lankan culture, the protracted and violent civil war, and the recognised profound psychosocial effects that this had on the population at the time during Mr S's formative developmental years. Additionally, we have also been able to use this information to assist in developing insight into Mr S's own personal narrative, where as a young child his father disappeared and he witnessed his mother committing suicide and as a young man he was a victim of torture. We also reflected on the recognised psychological and social issues of being an asylum seeker in the UK. We have concluded that all of these issues were significant in the understanding of Mr S's presentation with regard to his alcohol dependency

[238] 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

[239] 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

[240] 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

[241] Independent Police Complaints Commission (IPCC),report is not yet published

[242] PNC: Police National Computer

[243] 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)

and mental health, his lack of engagement with services, and his relationship with both Ms G and her partner. Additionally, we felt that they may well have also been a contributory factor in the events that led to the death of Ms G.

14.4 Mr S's presentation to primary and secondary mental health and addiction services was often contradictory in terms of his risk to himself and others. When he was sober he would be polite and compliant but he was clearly ambivalent with regard to engaging with support and abstinence. However, when we reviewed the police records, it was evident that alcohol was a significant and contributory factor in all of the incidents where Mr S was either the victim or the perpetrator. It was also evident that whatever the cause, there was clearly ongoing conflict between Mr S and Ms G and her partner. However, at no time was there evidence of any physical violence by Mr S towards Ms G, most of the incidents involved relatively low-level anti-social behaviour and there was no evidence of any significant escalation in the period preceding 6 August 2013.

14.5 Therefore, we have concluded that the incident on 6 August 2013 which led to Ms G's death was not predictable.

Preventability

14.6 In our consideration of the preventability of this incident, we have asked ourselves the following two questions. Based on the information that was known, were Mr S's risk factors and support needs being adequately identified and assessed? Additionally, was it reasonable to have expected individual practitioners to have taken more proactive steps to have obtained information from either Mr S or other involved services?

14.7 What was clearly apparent to us was that all services were operating and managing situations in isolation. Support was being provided to Mr S in response to the various crisis situations, but outside these situations no agency was able to manage to engage Mr S in an ongoing relationship. Information was not being shared between the various agencies, including the police; therefore, services and practitioners only had a fragmented knowledge and understanding of Mr S's issues. Therefore we concluded that no agency identified either the true extent of his ongoing risks to both himself and others or the fact that he had no significant protective factors.

14.8 We have therefore concluded that based on what was known at the time, the incident itself was not preventable. Had a more inter-agency approach been adopted, then information could have been shared and a more comprehensive profile of Mr S's presenting issues and needs could have been identified. However, we would suggest that given Mr S's issues, relating to his PTSD, his mental health and his alcohol dependency issues, it is likely that he would have continued to be a very vulnerable and unpredictable individual who until such time as he was able to resolve these complex issues would have remained at significant risk to both himself and others.

15 Concluding comments

15.1 During the course of our investigation, it became very evident that Mr S experienced many complex issues with regard to his mental health, alcohol dependency and the effects of his traumatic personal history. These issues were also compounded by his lack of secure employment and housing, social isolation and the psychosocial issues of being a refugee in the UK.

15.2 There was clearly multi-agency involvement with Mr S, but this took the form of providing a reactive service to Mr S and operating in their respective service 'silos'. This meant that information regarding his potential risk both to himself and others was not shared, fragmented support was offered to Mr S and there was a failure to engage him in any long-term treatment plan.

15.3 Although it was recognised that Mr S required specialist psychological intervention for his PTSD, this was a long-term plan that required him to be abstinent from alcohol before it began. However, we concluded that given Mr S's numerous immediate issues, it was difficult to see how he could have achieved this without considerably more intensive and appropriate support being available.

15.4 With regard to Mr S's cultural needs, we found no evidence to indicate that any agency paid particular attention to his cultural needs or considered what understanding Mr S may or may not have with regard to his mental health needs and the services that were being offered to him.

15.5 Finally, we concluded that although there were incidents where Mr S was perceived as the perpetrator of violence and public order offences, he was in fact a very vulnerable adult whose chaotic lifestyle was contributing to both his vulnerability and his risks to himself and others. Although the incident itself was not predictable, it was evident that at the time of the incident Mr S had no significant protective factors. Therefore, we would suggest that what was predictable was that whilst services continued to primarily focus on abstinence, there would have been a continued deterioration in Mr S's mental health and increased risks to both himself and others.

16 Recommendations

Recommendation 1

Somerset Partnership NHS Foundation Trust:

Recommendation 1: When assessing and providing support to patients whose first language is not English, primary and secondary care services must always consider the option of utilising an interpreting service.

Recommendation 2

Somerset Partnership NHS Foundation Trust:

Where it is known that a patient is experiencing financial or housing issues secondary mental health services should be identifying, as part of the patient's care planning, details of the relevant advocacy and support services and supporting them in accessing such services.

Recommendation 3

Somerset Partnership NHS Foundation Trust:

Where static long-term and acute risk factors have been identified as being significant, they must continue to be assessed and documented at this level until such time as it can be evidenced that there has been a significant change in a patient or that there are new robust protective factors in place.

Recommendation 4

Somerset Partnership NHS Foundation Trust:

For the safety and protection of both patients and staff, RiO's Physical Health Examination pro forma should include a body map that is used, with the patient's permission, to record any injuries, scars, bruises etc. on a patient's body. Somerset Partnership NHS Foundation Trust should introduce the appropriate guidelines regarding the use of body maps.

Recommendation 5

Somerset Partnership NHS Foundation Trust and Somerset Drug and Alcohol Service:

Both Somerset Partnership NHS Foundation Trust and the recommissioned Somerset Drug and Alcohol Service (SDAS) need to consider developing a specific policy, which includes consideration of the psychological, accommodation and social needs in the provision of services to refugees. Such a policy should include NICE's guidelines on supporting such patients with PTSD.

Recommendation 6

Primary Care Service:

Recommendation 6: The primary care service involved in this case should familiarise themselves with NICE guidelines regarding the provision of health care to refugee patients.

Recommendation 7

Somerset Partnership NHS Foundation Trust:

The Trust's Risk Assessments and Recovery Care Plans should have a section to indicate if a patient has been involved in the process. The form should also indicate if a patient has agreed with the assessment and if not it should be documented what are their reasons. Also the assessment and plan should indicate if the patient has been asked if they would like a copy.

Recommendation 8

Somerset Partnership NHS Foundation Trust:

Risk Assessments and Recovery Support plans should always identify and consider 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 and support.

Recommendation 9:

Somerset Partnership NHS Foundation Trust and Somerset Drug and Alcohol Service:

Somerset Drug and Alcohol Service (SDAS) and Somerset Partnership NHS Foundation Trust must agree a formal information-sharing protocol.

Recommendation 10

Somerset Partnership NHS Foundation Trust:

Authors of Serious Incident Reports must include evidence within their reports of the methodology that is being utilised within their investigations, for example Root Cause Analysis, a fishbone diagram, 5 Whys.

Recommendation 11

Somerset Partnership NHS Foundation Trust:

Authors of Serious Incident Reports must ensure that they are referring to all the relevant NICE guidelines that were in place at the time of the incident.

Recommendation 12:

Somerset Partnership NHS Foundation Trust:

The Trust's Safeguarding Adults at Risk Policy should direct practitioners to consider a patient's culture and ethnicity as being significant and interconnecting factors to both their vulnerabilities and their potential risks of being abused.

Recommendation 13

Somerset Partnership NHS Foundation Trust:

The Trust should adopt a universal action plan proforma and ensure that the relevant STEIS incident number is clearly documented on the original and on subsequent action plans.

Recommendation 14

Somerset Partnership NHS Foundation Trust:

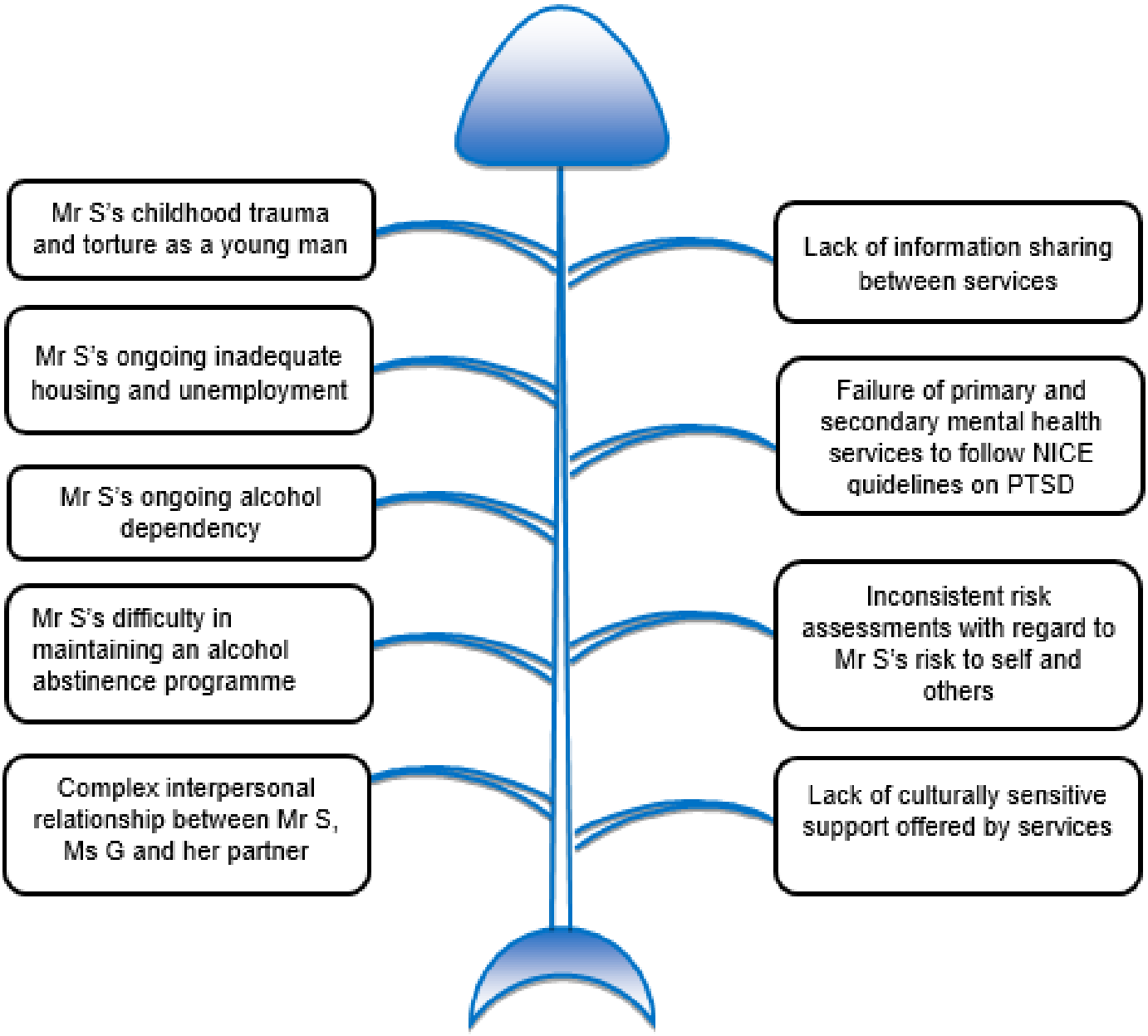
In order to ensure that all the action plans that have arisen out of this Serious Incident Report have been fully implemented, the Trust should undertake an immediate audit of each recommendation.

Recommendation 15

Somerset Partnership NHS Foundation Trust:

In order to evaluate the effectiveness of the new information-sharing systems introduced since this incident, the Trust should consider undertaking an audit exercise of a number of cases, involving similar complex patients, where there is both internal and external multi-agency involvement.

Appendix A**:** Fishbone Analysis



Appendix B Terms of reference

Review the engagement, assessment, treatment and care that Mr S received from Somerset Partnership NHS Foundation Trust, Turning Point, and his GP from his first referral in September 2012 up to the time of the incident on 6 August 2013.

Review the contact Mr S had with the above services and Avon and Somerset Constabulary and assess if Mr S's risks (to self and others) were fully understood and catered for.

Review the engagement of Turning Point and NHS mental health services with Mr S after his diagnosis with behavioural disorder and PTSD in April 2013 and consider the appropriateness of the pathways and treatment options in line with national standards and best practice.

Review the care planning and risk assessment for Mr S with particular consideration of how cultural issues were considered and whether this was in line with the organisations' policies and procedures and in compliance with national standards and best practice.

Review the communication between agencies and services, especially between the GP and the Trust, between the Trust and Turning Point, and between services within Somerset Partnership NHS Foundation Trust.

Consider the number of contacts that Mr S had with the police and whether further multi-agency working may have assisted in assessing the risk of Mr S to others.

Review and assess if the Trust could have done more to communicate with Mr S's known friends or family during his five admissions to hospital and after the incident.

Review the documentation and record keeping of key information by the healthcare organisations involved with Mr S against best practice and national standards.

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

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

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

To assess and review the Trust's family engagement as part of this investigation and consider if they complied with their policy for homicide and serious patient incidents, measured against best practice and national standards.

Appendix C Chronology

Date	Source	Event	Comment
January 2012	Police interview	Ms G's partner reported that Mr S moved from Scotland to Somerset.	
12 March 2012	GP notes	Mr S registered with GP.	
April 2012	Police interview	Ms G's partner moved in with Mr S.	
26 June 2012	GP notes	Mr S reported that he had an alcohol problem. He had recently restarted and was drinking four to five days a week. Prescribed Amitriptyline 25mg, Vit B compound and Thiamine Hydrochloride 100mg.	
July 2012	Police interview	Ms G moved in with Mr S.	
15 September 2012	Agency 1 records	Mr S was arrested for drink-driving. Offered appointment with agency 1 initially for 17 September but Mr S changed this to 19 September.	
19 September 2012	GP notes	GP appointment; Mr S reported that he had been away to India for ten days. Mr S attended appointment with agency 1 (custody drop-in) and an initial assessment was completed.	
29 September 2012	Agency 1 records	Mr S attended appointment with agency 1. Agency 1 offered treatment, but Mr S wanted to start this after his stress management course was completed.	
1 October 2012	Agency 1 records	Court hearing for drink-driving offence. DVLA course to be completed.	
15 October 2012	Agency 1 records	Mr S cancelled appointment at agency 1.	
17 October 2012	Agency 1 records	Mr S cancelled appointment at agency 1.	
20 October 2012	Agency 1 records	Telephone call with Mr S.	
23 October 2012	Agency 1 notes	Telephone call with Mr S where he alluded to suicidal thoughts.	Discussion with co-worker agreed no action to be taken as protective factors in place i.e. grandmother.
29 October 2012	Agency 1 notes	Meeting with agency 1. Mr S wanted to wait until he had completed DVLA driving course before starting with agency 1.	

10 January 2013	Agency 1 notes	As agreed agency 1 contacted Mr S to arrange meeting. Mr S said that he would call back the next day.	
14 January 2013	Police interview	Ms G moved into alternative accommodation.	
23 January 2013	Police records and police interview	From 2:54am Mr S made ten 999 calls to police. In the first six calls Mr S made allegations that Ms G and her partner were poisoning his food and that this had been occurring for several months. Advised by call dispatcher to stop taking their food and that he should use 101 not the emergency number. 3:01am Mr S called 999 saying that a man was trying to kill him. Alleged that housemate had pushed and hit him. Call graded as immediate response and police attended Mr S's accommodation at 3:38am. Ms G's partner reported that Mr S was using insulting language towards Ms G and her mother and when challenged Mr S held him by the neck and punched him. Ms G's partner did not want to make a complaint. Police control room completed an Anti-Social Behaviour form (ASB). 9:01pm Mr S called 999 reporting that Ms G was calling and texting him up to 30 times a day. He also reported that he had barricaded his bedroom door to stop Ms G and her partner coming in. Police call handler advised him to stay in his room. 9:15pm 999 call from Mr S reporting that he was scared of Ms G and her partner. Reiterated that Ms G was calling him 40 to 50 times a day and that she would come into his room at night. Police officer called Mr S and advised him to go to the Citizens Advice Bureau to obtain advice regarding his tenancy and also to request his landlord to put a lock on his bedroom door. A further ASB form completed.	Anti-Social Behaviour form: records details of the event and allows for repeat problems with locations and individuals to be monitored.
27 January 2013	Police records	9:49pm Mr S called 999 to report that he had been assaulted at a public house. He was in the toilet and a male approached and punched him. Initially alleged that the motive was racial, although he later denied this. During call it was noted that Mr S's speech was	

		slurred, and attending police officer noted that Mr S was intoxicated. Police took Mr S back to his home.	
28 January 2013	Hospital notes and police records	Police officer attended Mr S's accommodation to conduct further enquiries regarding the previous day's alleged assault. Mr S was presenting as very drowsy and uncoordinated. Mr S disclosed that he had taken an overdose of Amitriptyline and Thiamine and stated that he had been trying to end his life. Also alleged that Ms G and partner had been poisoning him. Mr S was admitted to an acute ward after presenting to A & E having taken an overdose. Following an assessment by a consultant psychiatrist Mr S was discharged to the Crisis Resolution and Home Treatment Team (CRHT).	
30 January 2013	CRHT and GP notes	CRHT telephoned Mr S. Mr S presented at GP with superficial burns on his arm. Reported that he had fallen against heater. Mr S informed GP that he had taken an overdose that weekend and was "hearing voices."	
31 January 2013	CRHT notes	Seen by CRHT team. Admitted that he had been drinking more than he was reporting.	
2 February 2013	Police records	8:18pm Call from Mr S reporting that Ms G's partner had pushed him and that he was making a noise. 8:18pm Call from Ms G's partner reporting that Mr S had hit him. Police officer attended, Ms G's partner reported that Mr S had punched him several times resulting in a cut above left eye. He did not want to make a complaint. Police noted that they resolved the situation as both partied agreed to the restorative justice process.	Restorative justice process requires face-to-face apology and the agreement of both parties.
4 February 2013	CRHT notes	CRHT telephoned Mr S. Mr S called agency 1 to inform them that he had been in hospital.	
5 February 2013	CRHT notes	Seen by CRHT team.	
7 February 2013	GP and police and agency 1 notes	GP appointment: Mr S informed GP that he had lost his job two weeks before. Was experiencing "stress" from other tenants. Reported that he had taken an OD, as "dying would be easier than living." and that he had been drinking	

		extensively for the last seven years. Med 3 issued by GP. Mr S rang agency 1 reporting that he was still drinking four to five pints daily. 8:30pm Mr S and Ms G's partner had argument. Witness reported that during altercation Mr S had grabbed a kitchen knife. Police noted that Mr S smelled strongly of alcohol. No charges brought and Ms G's partner left the property.	
9 February 2013	CRHT notes	Seen by CRHT team. Risk assessment reviewed. Mr S discharged from CRHT.	
10 February 2013	CRHT notes	Recovery Care Plan and risk screening completed.	Not evident if Mr S involved as he had been discharged from CRHT service.
14 February 2013	Agency 1 notes	Mr S attended appointment at agency 1. SADQ and AUDIT scores increased. Agreed that Mr S would be eligible for a detox. Mr S was taken to A & E as he had collapsed in the street. He is reported to have stated that he had drunk a bottle of whisky and some other alcoholic drinks. Mr S's friends who had accompanied him informed A & E staff that he had recently been involved with mental health services. Staff contacted the on-call CRHT for background information; they also reported that Mr S had made some "generalised comment about his life not being worth living." He was subsequently discharged from A & E.	
18 February 2013	Agency 1 notes	Mr S attended appointment at agency 1 for assessment. GP referred Mr S to Right Steps.	Right Steps: talking therapy service
19 February 2013	IRS log and GP notes	GP appointment: noted that Mr S reported that he was going to be evicted in two days and was seeing council the next day re. his housing situation. Med 3 issued. 4:06pm Mr S phoned 999 reporting that he thought his neighbours were poisoning him. 4:41pm Mr S called 999. Police dispatcher noted that Mr S was not making sense and was "rambling". Police attended but no action taken. 8:00pm Police received a call from manager of restaurant who reported that Mr S was drunk and being abusive to customers in his restaurant. When police arrived Mr S left. An ASB form	Med 3 sickness certification issued by primary care

		was completed under nuisance category.	
20 February 2013	Police Interview and notes	A friend of Mr S contacted the police reporting that she was concerned about his welfare as he had stated to her that he had nothing left to live for. A welfare check was carried out by police at Mr S's flat. Assessed that Mr S was not exhibiting signs of risk to himself or others. Officers gave Mr S contact details of the CRHT. Ms G's partner reported that Mr S made a threatening call to him where he said that he was watching him and Ms G. Mr S phoned again later asking for money.	
22 February 2013	Agency 1 notes	Mr S moved to Housing Association's emergency accommodation.	
23 February 2013	IRS log	From 12:43pm onwards Mr S made six calls to police. In the fourth call Mr S reported that he had been racially abused at a nightclub. In the fifth call Mr S reported that he was outside the police station and that he was cold and was going to die. He was advised to redial 999 and request an ambulance. In the sixth call Mr S reported that he was inside the police station.	
27 February 2013	Agency 1 notes and IRS log	Mr S attended assessment appointment with Dr at agency 1: noted that Mr S was "deeply traumatised by the loss of both parents in childhood and other aspects of the conflict – pt himself was tortured by the Sri Lankan military. Has no relative in the UK. Has no social support network locally. Pt very vulnerable – has been swindled previously by 'friends'. Pt not really eating – spending any money he has on alcohol. Newly re-housed in Yeovil – advised to register with a local GP asap – needs bloods inc. LFTs and also vitamin supplements and a proper medical review. Pt not suitable for community detox – will need in-patient detox with psychiatric input." Mr S moved to accommodation in close proximity to Ms G and partner.	Mr S moves to hotel (bed and breakfast emergency accommodation). Quote from letter to GP from Dr at Agency 1 not cc'd to secondary health care services involved with Mr S.

		Mr S called Right Steps to arrange telephone assessment on 8 March. 5:37pm to 5:43pm Mr S phoned 999 three times requesting that "he wanted help to return to his country." He was advised that police could not assist him. Noted that Mr S's speech was slurred. Mr S repeatedly saying that "he wanted to go back to Sri Lanka to die." and that he "came to the UK for a better life but we have treated him bad." Dispatcher informed him that this was not a police matter. Mr S then said "I will make it a police matter" and "people will call us when he has done what he needs to do." Noted that Mr S had been drinking. 6:08pm Mr S called 999 and gave his phone to a member of staff at his emergency accommodation. They reported that Mr S had been asked to leave as he was being a nuisance and upsetting other customers. Police unit dispatched and Mr S was removed from the premises but not arrested.	
28 February 2013	Police Interview	Ms G's partner reported that Mr S phoned both himself and Ms G stating: "I am not going to let you have your life."	
1 March 2013	GP notes	Registered with new GP surgery.	
6 March 2013	Crisis Assessment report Agency 1 and IRS notes	Mr S attended a support group at agency 1. Mr S reported that he also had a telephone assessment with Right Steps about counselling arranged for 8 March 2013. 5:42pm Mr S called 999 asking that the police take him to Sri Lanka as he wanted to go there to be killed. Call dispatcher informed Mr S that this was not their responsibility. 9:01pm Security manager called 999 reporting that Mr S was drunk and threatening staff and customers. Police dispatched, Mr S was arrested for being drunk and disorderly.	
7 March 2013	RiO and GP notes	Custody Sergeant requested a Mental Health Assessment and referral made to Court Assessment and Advice Service (CAAS). Assessment carried out by CAAS's nurse. Assessment highlighted significant risk indicators for suicide; arrangements made for follow-up by CRHT team (8 March).	

		GP notes: telephone encounter with CAAS worker. Noted: “Do not prescribe more than 1 weeks medication due to suicide risk.”	
8 March 2013	CRHT and GP and police notes	CAAS ST&R worker supported Mr S to attend appointment with CRHT. CRHT agreed to support Mr S, risk screen updated and liaison with agency 1. GP notes: new patient screen completed. Noted problem: “Alcohol dependency syndrome”. Blood screen taken. Liaison with agency 1 requesting GP to undertake full blood screen for planned detox admission. 5:29pm Transport Police and member of public contacted police to report that Mr S was lying on the train tracks. Police escorted Mr S under s136 to acute ward for a Place of Safety Assessment. Mental Health assessment placed him on a Section 2. Detox programme commenced. Risk screen updated.	Section 2: 28 days for assessment
14 March 2013	GP notes	Liaison with CRHT re. admission.	
15 March 2013	RiO notes	Section 2 removed.	
18 March 2013	RiO notes	Mr S discharged from hospital.	
19 March 2013	CRHT and IRS notes	Seen by CAAS and CRHT workers at home. Arrangements included psychological assessment, appointment with employment service and GP. Risk screen updated. Informed. 8:19pm Mr S called 999 to report that he had been ejected from a pub. A witness reported that Mr S had been drinking, had become abusive and fallen over and sustained a deep cut to his hand. Police attended. 10:51pm Mr S called 999 reporting that he was at a fast food establishment. Claimed he had been assaulted two hours previously and that the attending officers were racist and criminals. Call handler noted that Mr S sounded extremely intoxicated. Mr S passed phone to the person who had lent him his phone who reported that Mr S had several cuts and scratches and that he thought that he needed to be medically checked. Ambulance and police	NB started drinking day after discharge

		attended. Police escorted Mr S to his home address.	
20 March 2013	Agency 1 notes	Mr S DNA appointment with agency 1.	DNA did not attend
21 March 2013	GP notes	Mr S attended GP appointment with superficial cuts to his hands and wrists. Prescription issued for: Diazepam 5mg (twice daily); Mirtazapine 15mg (one at night); Vit B compound (once daily). Noted "mental and behavioural disorder due to use of alcohol". Attended meeting with agency 1 detox nurse. Referral made by CRHT to Right Steps. Mr S attended meetings with Housing Office, Job Centre and Bank with CAAS STR worker.	Right Steps discharged Mr S as he did not respond to their opt-in letter.
22 March 2013	RiO notes	Mr S attended court and was given unconditional bail.	
25 March 2013	Agency 1 and IRS notes	Mr S did not attend group at agency 1. 7:27pm Mr S called 999. Reported that a male had been racist towards him. Call handler noted that Mr S sounded intoxicated and was in a public house. He handed the phone to a male who worked in the public house who reported that Mr S had been ejected from the premises as he was being aggressive. No police officers deployed. 7:47pm Mr S called 999. Said that he wanted to go back to Sri Lanka; he then became abusive and call was terminated by call handler. 7:50pm Mr S called 999 requesting to be put through to the Sri Lankan embassy. Advised by call handler that he had to call the embassy direct.	
26 March 2013	Agency 1 notes	Telephone discussion between agency 1 and CAAS re. update on court case and Mr S's recent hospital admissions.	
27 March 2013	RiO and GP notes	Mr S attended appointment with GP accompanied by CAAS STR worker. GP contacted agency 1 to advise them that Mr S had relapsed.	
28 March 2013	GP notes	Seen by GP. Prescription issued. Noted that Mr S reported that he was drinking one to two pints "on occasion" and appeared "lucid".	

		Mr S went to agency 1. They explained to Mr S that he had to stop drinking before he could attend groups. Agency 1 discharged Mr S from their services as he was drinking again and not suitable for the service. GP informed.	
30 March 2013	IRS log and RiO notes	7:43pm Mr S phoned 999 stating that he "wanted to go to the mental hospital and also to Sri Lanka". Call handler advised him to call a taxi if he wanted to go to hospital. 7:46pm Police received a call from ambulance service stating that Mr S had called them via 111 service. They believed that Mr S might be suicidal and that they required police to attend as Mr S had become agitated. Police and paramedics attended. Mr S reported that he had taken a month's worth of medication. Mr S taken to A & E. Not assessed as suicide risk and discharged. Risk screen updated.	
1 April 2013	IRS log	12:07am. Ambulance service contacted police to report that they had attended Mr S's address as they were concerned about his welfare. When they arrived Mr S was claiming that another occupant was torturing him and he was threatening to kill them. They requested that the police attend as they were concerned. 12:12am Mr S contacted 999 asking to be taken to hospital where he felt safe. He initially reported that he was at his home address, then that he was at Ms G and her partner's address. Police assessed his risk as medium (due to recent OD) but noted that Mr S was not threatening to harm himself and wanted to go to hospital as a place of safety. Police contacted CRHT service; they advised police to contact the inpatient unit. Unit informed police that they had been in contact with Mr S for most of that evening and there was nothing they could offer him. They had advised Mr S to contact agency 1. 12:25am Ambulance crew arrived. 12:33am Mr S refused to go in ambulance stating that he wanted police to take him to hospital. 1238am CRHT reported that they had no concerns and therefore police decided it "was not a police matter".	

		Force Incident Manager decided that if CRHT had no concerns for Mr S's safety then this was not a police matter. 12:44am Mr S rang police again, stating "if he does anything bad … now saying if that's the way you want to do it then that's the way he'll do it." He then terminated the call. Police decided that they would not be transporting him to hospital. 12:55am Ambulance service contacted police to report that they had attended Mr S's address and that he was unconscious but breathing. The occupants of the address were refusing paramedic entry, so crew requested police back-up. 1:20am Paramedics and police gained access and assessed that Mr S was conscious and had not taken an overdose. Advised Mr S to talk to his mental health worker.	
2 April 2013	RiO and GP notes	Seen by CAAS worker. Seen by GP, prescription issued. Mirtazapine increased to 30mg. Noted that Mr S had run out of medication early.	
4 April 2013	IRS log, RiO and GP notes	Seen by CAAS worker. Case re. drunk and disorderly had been dismissed. Seen by GP: noted that Mr S had OD'd on medication issued on 28 March. Noted that he was to "go on 3 times weekly dosing: diazepam (5mg) taken one twice daily Wednesday and Thursday; Mirtazapine 30 mg one at night Wednesday and Thursday and vitamin B take one daily." Full blood screen. 10:39pm Mr S called police reporting that he wanted to go to Sri Lanka where he would be shot. Mr S stated that "staying in UK is a slow death and he'd prefer a quick one." He informed the police dispatcher that he was on methadone. Dispatcher encouraged him to contact his GP. Call lasted 20 mins. Call ended with Mr S saying that he did not need police help. Second call (time not available): again Mr S stated that he wanted to return to Sri Lanka; also alleged incident of racist abuse. Third call (time not available): again stated wanted to go to Sri Lanka.	Medication being issued 3x weekly dispensing of prescriptions

		11:11pm Three calls: said he wanted to go to Sri Lanka “to be killed”. Speech became slurred and he disclosed that he had taken 20 tablets. Ambulance and police units were dispatched. Mr S reported that he had not taken an OD but that he had been drinking.	
5 April 2013	GP notes	Mr S seen by GP: issued a prescription for: Diazepam 5mg – take one twice daily Friday, Saturday, Sunday; Mirtazapine 30mg – one at night Friday, Saturday, and Sunday. Seen by CAAS worker. Discharged from CAAS service.	
7 April 2013	IRS log	6:06pm Mr S phoned 999 to report that a man was trying to enter his house. Police unit dispatched. 6:59pm Mr S called 999 stating that he wanted to return to Sri Lanka because he would “be killed if he remained in England.” 7:11pm Mr S reported that police had come to his address and that they had taken “their” side. Attending police noted that this was a civil matter involving a debt and they advised Ms G’s partner to contact solicitors. Mr S phoned 999 reporting that if he stayed in England he would be killed. Dispatcher advised Mr S that it was not a police issue and that he should contact the Border Agency. 7:24pm Mr S phoned 999 again stating that he wanted to return to Sri Lanka. He was advised to contact the Border Agency. Claimed that he would be killed by Ms G’s partner if he remained in the UK.	Possibly Ms G and partner. Debt relating to car sale or end of tenancy.
8 April 2013	RiO and GP notes	Seen by GP. Prescription issued: Mirtazapine 30mg, one at night, Wednesday, Thursday; Diazepam 5mg, one twice daily, Wednesday, Thursday; Vit B compound, take one daily.	
12 April 2013	GP notes	Seen by GP. Prescription issued: Mirtazapine 30mg, take one at night, Friday, Saturday, Sunday; Diazepam 5mg, take one at night, Friday, Saturday, Sunday.	
15 April 2013	GP notes	Seen by GP. Prescription issued: Mirtazapine 30mg, Diazepam 5mg, Monday, Tuesday, and Wednesday.	

18 April 2013	GP notes	Telephone consultation. Noted that now changed to twice weekly prescriptions: Mirtazapine 30mg and Diazepam 5mg (Thursday, Friday, Saturday, Sunday).	Change to twice weekly prescriptions issued
22 April 2013	GP notes	Prescriptions issued (Thursday, Friday, Saturday, and Sunday).	Mr S not seen by GP
25 April 2013	GP notes	Prescriptions issued (Monday, Tuesday, and Wednesday).	Mr S not seen by GP
29 April 2013	Police interview	Ms G's partner reported that Mr S had moved.	
2 May 2013	GP notes	Telephone encounter: prescriptions issued (Thursday, Friday, Saturday, and Sunday). Documented that Mr S did not want to engage with counselling service. Med 3 issued recommended suitable for part-time work.	
9 May 2013	GP notes	Seen by GP: noted that "patient condition is steadily improving. Making progress with financial affairs and getting a job, More positive, switch to weekly scripts."	Weekly prescriptions commence
16 May 2013	IRS log	12:11am Ms G's partner called 999 to report that he had received a text from Mr S that stated "I'm in trouble call the police." Dispatcher called Mr S's mobile. He reported that he was unable to talk "as the people who are there are causing him a problem and did not know that he had called for help." He also reported that he did not feel safe "as the people there are causing his problems." Due to previous concerns regarding Mr S's welfare a police unit was dispatched. 12:30am Mr S called 999 reporting that he had information about a robbery and that he was at the location of the robbery and may be at risk. 12:45am Police attended. Mr S was with friends and he then left the property. One friend reported to police that Mr S had been drinking and had a "paranoid episode" at his friend's house. Police escorted Mr S to his home address.	
21 May 2013	GP notes	Prescriptions issued.	Last prescription issues
31 May 2013	SIR and police records	2:07am Mr S called 999 reporting that a group of people armed with a metal bar and knife were attacking him. Police dispatched. When police arrived Mr S was in possession of a metal bar at shoulder height and started to move towards police officers. Police requested that he put the bar down; when he	Red dotting: pointing a taser at a subject and using the laser sight to notify them that the taser, which projects a red dot on subject, is being pointed at them. Subsequent police enquiries revealed that Mr S was actually the victim

		refused, they used their taser in a sequence known as “red dotting.” Mr S put metal bar down. A bread knife was also located at the scene. One of the other individuals was bleeding heavily from a cut to their hand. Mr S was arrested for wounding with intent and for possession of an offensive weapon in a public place. He was bailed pending further enquiries. CAAS service requested advice about Mr S following his arrest for assault (wounding with intent with a metal bar).	and that he had disarmed the others shortly before police arrived.
7 June 2013	Police interview	Ms G returned from a week’s holiday in France.	
8 June 2013	Police records	10:34pm Mr S called police to report that he had been racially abused at a local hotel. Call dispatcher noted that Mr S appeared to be intoxicated. Police attended. Witnesses reported that they had not witnessed any racial abuse. Mr S escorted from the premises.	
19 June 2013	Police records	5:30pm Mr S called police stating that he wanted to return to Sri Lanka. Appeared to be intoxicated. Call dispatcher informed Mr S that this was not a police matter.	
20 June 2013	Police records	3:46pm Mr S called police stating that he wanted to talk to police officer about the country and also stated that he could be killed at any time. Call dispatcher advised him to call 101 non-emergency services. 3:54pm Further call to the police by Mr S, reporting that he knew that there were people trying to destroy the country. Noted that Mr S sounded intoxicated although he denied that he had been drinking. Third call to police (time not recorded). Mr S became obstructive and abusive. Call terminated by call dispatcher. 7:35pm Ms G’s partner called police stating that there was a man outside his address knocking on the door and scaring his girlfriend. He reported that this was a regular occurrence. He identified the person as Mr S. Officers deployed but when they arrived Mr S had left the scene. Incident log noted that this would be passed on to local beat officer. Later that day Ms G’s	Girlfriend not located by police or SIR Not evident if police gained entry to Ms G’s property or

		partner called police again to report that Mr S was outside his flat again and that Ms G was alone in the property. Police completed an ASB form, category nuisance. Throughout the day Mr S placed several calls (times not noted) to the police in which he appeared to be intoxicated and was repeatedly abusive to call handlers.	if Mr S was present when police arrived.
25 June 2013	GP notes	Seen by GP: noted that Mr S "was more stable recently, no overdoses. Got into a fight at a bar but not charged … Thinking of moving back to Glasgow as potential job opportunity has arisen. Happy with current meds, Eating better. Continue with weekly (prescription) regime."	Last time seen by GP
28 June 2013	Police interview	Ms G and her partner went away to look for alternative employment and accommodation.	
11 July 2013	Police records	6:20pm Ms G's partner called police reporting that a person (later identified as Mr S) was trying to gain access to their property. Reported that Mr S was intoxicated. 6:54pm Ms G's partner called police again to notify them that Mr S had left the scene. Police attended and interviewed both Ms G and her partner. Police assessed that this was a low-level ASB. Police attended Mr S's accommodation. Mr S alleged that Ms G's partner had telephoned him. Officers asked to see Mr S's mobile phone, and noted that there was evidence of communication between Mr S and Ms G's partner. Officers noted that they then proceeded with the restorative justice process. Officers instructed Mr S not to attend Ms G and her partner's address and gave him a warning with regard to his actions, telling him that any further incident would lead to him being arrested. Attending police officers deleted Ms G's partner's contact details from Mr S's mobile phone. They also advised Ms G's partner not to make any further contact with Mr S.	Not evident if they deleted Ms G's contact details from Mr S's mobile phone

5 August 2013	Police interview and GP notes	Ms G's partner arranged to meet Mr S at library. Mr S reportedly said: "I'm not going to disturb you any more I'm going, I'm going to move this week, and in future there won't be any trouble for you." Telephone consultation with GP: Mr S reported that his alcohol consumption was down to once a week. Agreed to continue collecting with weekly prescriptions.	Last telephone contact with GP
6 August 2013	Police interview	Day of the incident: 1:06pm Ms G phoned the mobile of Mr S (call lasted 20 seconds, contents of call not known) 2:00pm Mr S was seen at a betting shop. 4:30pm Ms G's partner left property. 4:45pm (approx.) Ms G's partner reported that he had seen Mr S with his girlfriend. 4:48pm Ms G last spoke to her partner (mobile call). 4:57pm Ms G sent a text, recipient unknown (last activity on her mobile phone). 5:00pm to 6:00pm Neighbour heard a male voice and Ms G's letter box rattle. Believed Ms G had let someone into her flat. Between 5:00pm and 6:48pm Mr S made 13 calls using his mobile. One call lasted 46 mins and 13 seconds. Between 8:00pm and 8:10pm a neighbour heard raised voices and banging noises coming from Ms G's flat. At approximately 8:15pm two women arrived in the parking area. Whilst they were sitting in the car talking, the driver became aware of a man looking out of one of Ms G's windows. One of the women then got out of the car and saw Ms G at the window with her arms outstretched, shouting, and "Help me." Ms G was then dragged away from the window into her flat. 8:24pm Mr S called police and reported that "I have just done a murder," 8:25pm Police arrived at scene. 8:26pm Police gained entry via a window and arrested Mr S. 8:30pm Paramedics arrived. 8:37pm Paramedics certified Ms G was dead.	

Appendix D References

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