VERITA

IMPROVEMENT THROUGH INVESTIGATION

Independent investigation into the care and treatment of Mr R

A report for
NHS England, South Region

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1. Introduction

NHS England, South Region commissioned Verita, a consultancy specialising in public sector investigations, reviews and inquiries, to carry out an independent investigation into the care and treatment of Mr R.

The independent investigation follows the Department of Health guidance published in HSG (94) 27, *Guidance on the discharge of mentally disordered people and their continuing care in the community*, and the updated paragraphs 33–36 issued in June 2005. The terms of reference for this investigation are given in full in section 2 of this report**.**

The purpose of an independent investigation is to discover what led to an adverse event and to audit the standard of care provided to the individual. An independent investigation may not identify root causes or find aspects of the provision of healthcare that directly caused an incident, but it will often find things that could have been done better.

1.1 Background to the independent investigation

At the time of the incident Mr R was being treated by the Assertive Outreach Team[1] (AOT) based in Aylesbury, Buckinghamshire. He was a detained patient under Section 3[2] of the Mental Health Act 1983 (MHA) and was on leave under Section 17[3] of the MHA from a general adult ward. He was diagnosed with a bipolar disorder and he misused drugs and alcohol. He had a long forensic history, including disorderly conduct, robbery and actual bodily harm. He received care and treatment as an inpatient under the MHA on several occasions.

1.2 The incident

Mr R assaulted Mark Austin[4] on the night of 30 January 2013. He was arrested on 31 January 2013 on suspicion of causing life-threatening injuries to Mark. The Oxford Health NHS Foundation Trust was informed on 1 February 2013 that Mark had died in hospital of his injuries. The immediate causes of death were reported as shock, haemorrhage and blunt trauma. While in custody Mr R was recalled under the MHA. He was convicted of manslaughter on 24 February 2014.

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[1] As of March 2014 the trust restructured its services into three directorates. AOT no longer exists; rather it forms part of a locality model of adult mental health services.

[2] Section 3 of the MHA can be used after a section 2 has expired. It can also be used if a patient is known to mental health services and does not need to be assessed for Section 2 (http://www.legislation.gov.uk/ukpga/1983/20/section/3)

[3] Section 17 leave allows patients to leave hospital subject to conditions set by their clinician. Failure to adhere to the conditions may result in the patient being recalled to hospital (http://www.legislation.gov.uk/ukpga/1983/20/section/17)

[4] At the request of his family we have referred to Mark Austin by name throughout this report. He is referred to either as Mark Austin or Mark.

1.3 Overview of the trust

Oxford Health NHS Foundation Trust is a provider of a wide range of physical, community health, mental health and social care services. The trust offers services across Oxfordshire, Buckinghamshire, Wiltshire, Bath and North East Somerset.

The trust provides four primary groups of service:

- mental health services (for adults and older people, offering inpatient and community services across Oxfordshire and Buckinghamshire);
- Oxfordshire community services (supporting individuals with long-term conditions and rehabilitation needs);
- children and family services; and
- specialist services (forensic mental health needs and hard-to-reach groups e.g. offenders).

2. Terms of reference

The terms of reference for the independent investigation, set by NHS England, South Region in consultation with Oxford Health NHS Foundation Trust, are as set out below.

1. Review the assessment, treatment and care that Mr R received from Oxford Health NHS Foundation Trust up to the time of the incident.
2. Review the care planning and risk assessment policy and procedures and compliance with national standards.
3. Review the communication between agencies, services, friends and family, including the transfer of relevant information to inform risk assessment.
4. Review the documentation and recording of key information.
5. Review the communication, case management and care delivery.
6. Review the trust's internal investigation, assess the adequacy of its findings, recommendations and action plan and identify:

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

2.1 Purpose of the investigation

To identify if any aspects of the care Mr R received could have been altered or prevented the incident. The investigation process should also identify areas where improvements to services might be required, which could help prevent similar incidents from occurring in future.

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

2.2 Main objectives

1. To establish if the risk assessment and risk management of Mr R were sufficient in relation to his needs, including the risk of Mr R harming himself or others.
2. To evaluate the mental health care and treatment Mr R received, including the adequacy of the risk assessment and risk management.
3. To identify key issues, lessons learnt, recommendations and actions by all those directly involved in providing the care plan.
4. To assess independently and provide assurance on the progress made on the delivery of action plans following the internal trust investigation.

5. To identify lessons and recommendations that have wider implications so that they are disseminated to other services and agencies.
6. To identify care or service delivery issues, along with the factors that might have contributed to the incident.

3. Approach to the independent investigation

Verita agreed with the commissioners to conduct an investigation that did not seek to reinvestigate the case from the beginning if the internal review was robust. This investigation was commissioned to build upon the investigative work that had already taken place.

The investigation team consisted of Kathryn Hyde-Bales, senior consultant, and Andy Nash, associate. Dr Martin Lock, consultant psychiatrist, provided expert advice and undertook a review of Mr R's clinical records. Tariq Hussain, senior consultant, peer-reviewed the report. Their biographies are in appendix A.

We reviewed documentary evidence, including policies and procedures from the trust, Mr R's clinical records and the trust internal investigation report. A list of documents reviewed is included in appendix B.

We interviewed the following staff:

- the clinical director of the adult mental health directorate;
- the lead investigator of the trust internal investigation (a consultant psychiatrist and medical lead for eating disorders); and
- members of the AOT, including its former consultant psychiatrist.

We shared our draft report with the clinical director of the adult mental health director, the lead investigator of the trust internal investigation and the former AOT consultant psychiatrist. We invited them to comment on our report and took their feedback into consideration as part of our review process.

Mr R did not give us consent to view his medical records. In line with NHS guidance, the trust Caldicott Guardian[1] agreed to release Mr R's medical records on public interest grounds to enable the investigation to be undertaken thoroughly.

We offered to meet with Mr R; however, he declined to see us. We sent Mr R a copy of our investigation report to comment on prior to publication.

We met with Mr R's family to discuss their experience of Mr R's care and treatment.

Steps were taken by NHS England to contact the Mark Austin's family to inform them of the independent investigation; however, it was unable to make contact. We wrote to Thames Valley Police asking if they could help facilitate a meeting with Mark's family. The police provided contact details for the family whom we subsequently contacted and arranged to meet. We met with five members of Mark's family, a family friend and their police liaison officer to discuss our provisional findings. During the meeting they told us what their concerns were and outlined areas that they wished to be taken into further consideration. Where appropriate amends have been made to the report in light of their concerns.

[1]The Caldicott Guardian is responsible for overseeing patient confidentiality, patient information and agreeing appropriate information-sharing (http://www.connectingforhealth.nhs.uk/systemsandservices/infogov/caldicott)

We also wrote to the police asking for information about interagency working between the police and the trust mental health services.

All the evidence received was analysed. Findings and recommendations have been made to improve services.

This report includes a chronology outlining the care and treatment of Mr R. The analysis appears in sections 7 to 16 where particular issues and themes are highlighted.

Our overall conclusions appear in section 17.

Verita agreed to give a final presentation of the investigation to NHS England or the clinical commissioning group as required.

4. Executive summary and recommendations

NHS England, South Region commissioned Verita to carry out an independent investigation into the care and treatment a mental health service-user Mr R.

4.1 The incident

On the night of 30 January 2013 Mr R visited the home of a friend. The victim, Mark Austin, was also present at the home. Mr R attacked Mark and punched him a number of times in the abdomen. After the attack Mr R left and returned to his flat.

Mr R was arrested on 31 January 2013 on suspicion of causing life-threatening injuries to Mark. Mark died in hospital. Mr R was convicted of manslaughter in February 2014.

4.2 Overview of care and treatment

Mr R had an extensive mental health history. He was first admitted to mental health services in 1983. Our analysis focuses primarily on Mr R's care from January 2012 up until the time of the incident.

Mr R engaged regularly with mental health services between 1983 until the offence in January 2013. During this 30-year period Mr R was admitted more than 30 times to psychiatric facilities either voluntarily or as a detained patient under the MHA. He was regularly seen by the AOT. Mr R's main diagnosis was a bipolar affective disorder.

Mr R had a history of violence and was known to the police. In 1999 Mr R was convicted of grievous bodily harm and then detained under Section 37[1] of the MHA. In 2008 he was charged with actual bodily harm and received an 18-month community sentence, the conditions of which included his medication being monitored by the AOT.

The AOT became increasingly engaged with Mr R in 2012. In May/June Mr R's condition began to deteriorate and it was noted on 11 June that he had started to show early warning signs of relapse and that he should be closely monitored. He was noted to have increased his alcohol consumption and continued to deteriorate. On 19 July his social worker concluded that his mental health was gradually relapsing.

Mr R was admitted informally to a mental health ward at the trust on 21 July. Staff were advised to detain him if he tried to leave. Mr R became threatening and

[1] Courts may direct that the convicted perpetrator of an offence punishable by imprisonment, be admitted to and detained at a hospital or under the guardianship of the local authority (http://www.legislation.gov.uk/ukpga/1983/20/section/37)

aggressive towards staff on the ward. He was detained under section 2[1] of the MHA on 23 July 2012.

Mr R was assessed by Dr1 (the AOT consultant psychiatrist), an approved mental health professional (AMHP) and independent S12 doctor[2] on 8 August. It was concluded that Mr R remained hypomanic and a risk to himself and others. He was detained under MHA section 3.

It was agreed at a ward round in late August that Mr R could start taking short periods of unescorted leave. Dr1 informed Mr R's mental health tribunal in September that Mr R had only made a small improvement and should remain detained. Then Dr1 and the AOT started to explore managing Mr R under a community treatment order (CTO)[3].

Mr R's ward clinical team agreed on 24 September that he should be granted extended leave at home for a trial period. A condition of this leave was that Mr R attend the ward to receive his medication. Mr R failed to comply with this condition and was subsequently aggressive towards AOT staff. It was agreed at the clinical team meeting on 27 September that Mr R should have his leave rescinded. Mr R was assessed and returned to the ward the same day.

Extended section 17 leave was tried again on 15 October. On 7 November it was felt that Mr R was not engaging with the AOT and consideration was given as to whether he should be recalled to the ward. The team learnt that a bed was not available for his recall. His plan was revised and the AOT continued to see him in the community.

Mr R attended the AOT office on 10 January 2013 in a distressed state. He asked to be admitted. He was seen by Dr1, who felt that Mr R had experienced a mild relapse but could continue to be treated in the community. Mr R was seen again the following day and was notably calmer. After this Mr R was seen by the AOT in the community until the incident on 30 January 2013.

4.3 Overall conclusions of the independent investigation

Mr R had an extensive mental health history dating back 30 years and he had been admitted to mental health facilities more than 30 times by 2012. He was well known to the AOT, which worked hard to engage with him and manage his illness. We have explored the familiarity of the team with Mr R's case and whether this had an impact on the level of care given to him in terms of his diagnosis and risk. The AOT and the trust internal investigation report both stated that this level of familiarity did not

[1] Section 2 of the MHA is the process by which a patient is detained at a hospital because of concerns about his or her mental health and safety (http://www.legislation.gov.uk/ukpga/1983/20/section/2)
[2] When a patient is assessed for section, two doctors and an AMHP must be involved, one of whom must have specialist experience in the diagnosis or treatment of a mental disorder – an S12 doctor. An S12 doctor must be approved by the Secretary of State (http://www.andrewsimscentre.nhs.uk/filestore/documents/National_Criteria_for_England_rev2_9.pdf)
[3] A community treatment order (CTO) is a means by which patients sectioned under the Mental Health Act receive treatment in the community subject to adherence to the conditions set, e.g., that they receive their medication in injections. The patient is not discharged from the care of his or her responsible clinician and failure to meet the conditions can lead to a patient being recalled to hospital

impact on its assessment of Mr R. The AOT made extensive efforts to engage with Mr R, but we noted that there were occasions when a team less familiar with the patient may have taken steps to explore issues further, the details for which we outline below.

Mr R had a long-standing diagnosis of a bipolar affective disorder. Care professionals attributed, at times, aggressive and intimidating behaviour to his personality rather than consider it a feature of his diagnosis. We believe that the team's familiarity with Mr R may have been a factor in this acceptance. We concur with Mr R's diagnosis; however, we believe that he also fulfilled the criteria for the diagnosis of an antisocial personality disorder.

Mr R's forensic history was not documented in detail by the AOT. As a result we are unclear whether the team was aware of the true extent of Mr R's violent behaviour and the risk that he could pose. Mr R was not referred by AOT to forensic services for an assessment. In 1999 he was transferred from court to Bowden House, an inpatient forensic unit, under section 37 of the MHA following a conviction for grievous bodily harm.

In the latter stages of his care, staff did not believe a forensic referral would have led to a change in his treatment, whether he was in hospital or community based. We believe that there would have been merit in referring Mr R to forensic services for assessment. We acknowledge that he may not have been accepted by the service; however, a referral would have provided an opportunity to review Mr R's diagnosis and treatment plan. Forensic services could have provided the AOT with a different approach or advice about treatment options and alternative methods of managing Mr R. Similarly, we believe that there would have been value in seeking information from other agencies such as the police with a view to building up a more accurate profile of Mr R.

The information from forensic services and the police could have been fed into Mr R's risk assessment. The team documented and managed Mr R's risk, but we believe that at times it underestimated the indicators of an antisocial personality disorder. We believe the team did not effectively explore alternative options for managing Mr R such as recourse to mental health law and other legal remedies to address his non-compliance, for example, referring Mr R to MAPPA or encouraging the police to pursue prosecutions for alleged offences. We acknowledge that Mr R might not have met the criteria for MAPPA however it would have opened a dialogue with the police. In 2012 Mr R often failed to comply with the conditions of his long-term leave. It was briefly considered whether he should be recalled to the ward but a bed was not available and the team continued to manage him in the community. There is no evidence that the team explored alternative options to managing Mr R when an inpatient bed was not available.

Mr R was treated with antipsychotic medication throughout his care and consistently with a mood stabiliser. Between 2008 and 2011 Mr R was prescribed clozapine[1], to which he responded well for a time but refused to keep taking it because of the side

[1] An antipsychotic for treatment-resistant schizophrenia (http://www.patient.co.uk/medicine/clozapine.htm)

effects that he experienced. As a result the team explored different treatment options for Mr R and in the latter stages of his care consideration was given to the use of depot medication[1]. The team was aware, however, that there was no guarantee that Mr R would comply with the conditions, which included lengthy periods of observation.

The AOT was exploring other means by which to manage Mr R. In late 2012 the team was using his long-term leave to test the feasibility of implementing a CTO. We were told that they had been considering it for some time but could only feasibly start taking steps to implement it after Mr R was put on long-term leave in the autumn of 2012. The purpose of this was to try to engage Mr R in the process. Although there was no guarantee that Mr R would comply with the proposed CTO, we were told that he had been most compliant in adhering to the conditions of a probation order in 2008. The CTO was scheduled to be implemented in early February 2013.

We have noted that there were areas of care and treatment that could have been explored further; however, on the whole the team was very committed to Mr R and provided him with a good level of care.

We have considered the circumstances, information and means available to the AOT at the time of the incident in January 2013 and conclude that the team could not have predicted the incident nor was it in a position to have prevented it.

The trust undertook a comprehensive internal investigation that addressed the terms of reference and made clear recommendations in relation to improving practice.

4.4 Findings

We conclude that Mr R's long-term diagnosis of a bipolar affective disorder did not change although there were indicators that he may have had an antisocial personality disorder.

The AOT and consultant psychiatrist made extensive efforts to engage, assess and manage Mr R.

Mr R's risk was considered seriously by the AOT but they made too many allowances for Mr R's antisocial behaviour, underestimating the indicators that he possibly had an antisocial personality disorder.

Mr R should have been referred to forensic services for assessment and advice about his management.

The AOT consistently attempted to engage with Mr R; however, they did not comprehensively explore alternative options such as mental health law and legal remedies when Mr R was non-compliant.

[1] Long-acting injectable antipsychotic medication

Mr R responded well to clozapine but the side effects were considerable and in 2011 he refused to continue taking it.

We agree that the option of using a CTO for Mr R was appropriate.

The trust internal investigation was comprehensive and underpinned by root cause analysis (RCA). It addressed the terms of reference and set clear recommendations in relation to areas of concern.

4.5 Predictability and preventability

Based on Mr R's psychiatric and forensic history we conclude that it could reasonably be predicted that Mr R may be violent at some time but the degree of that violence was unknown. However it was not possible for AOT staff to predict in January 2013 that Mr R would be imminently violent or the level of this violence.

We found that Mr R's presentation during the week preceding the incident provided insufficient grounds for the AOT to arrange a MHA assessment with a view to admission. Based on this we conclude that it was not possible for AOT staff to have prevented the death of Mark Austin.

4.6 Recommendations

There has been a significant overhaul of mental health services at the trust in the past 18 months. The AOT no longer exists and a new service model was introduced in April 2014. As a result of this we anticipate that it will take time before the new model and ways of working are fully embedded at the trust.

1. When service users have an extensive forensic history and present a significant risk to others, consideration should be given to referring for a forensic psychiatric opinion.

2. We recommend that the trust review the effectiveness of the new service model in 12 to 18 months. The trust should reflect on the recommendations of the trust internal investigation to ensure that progress of their implementation continues to be made within the new service model. In particular, attention should be given to the patient pathway and implementation of the new electronic patient record.

5. Chronology of care and treatment

5.1 Personal history

Mr R was born in Chelsea, London. His father is from the Caribbean island, Montserrat, and his mother is from Jamaica.

At the time of the incident Mr R was in receipt of incapacity benefit and disability living allowance. He was a tenant of Aylesbury Vale Housing Trust and had his own independent flat. The flat is in a small block with a common entrance. Records show that Mr R took drugs and drank alcohol with people who visited the flat. He has been evicted from some of his previous addresses including two group homes.

Mr R was typically liked by others and was known to have a number of friends. He was described as a “character” and a “loveable rogue” but Mr R could be unpredictable, violent and aggressive at times.

5.2 1983 until 1993

The trust internal investigation records that Mr R was first admitted to mental health services in March 1983 under the Mental Health Act 1959[1]. He was described as being restless, neglecting himself, talking incoherently and suffering from psychotic symptoms. He had been smoking large amounts of cannabis. He was treated successfully with antipsychotic medication and discharged after two months to live with his parents in the community.

Mr R was admitted twice to a hospital in Montserrat in October 1983 while on holiday.

Mr R was admitted to St John’s Hospital in Stone, Aylesbury in January 1984. Records described him as restless, with pressure of speech, and that he appeared to be suspicious. He was aggressive and hostile in his behaviour. He had not been taking his prescribed medication and had been smoking cannabis. He required large doses of antipsychotic medication to manage his psychosis. He stayed in hospital for seven months. He was discharged into the community on a combination of mood stabilisers.

Mr R was admitted to Guy’s Hospital in London in May 1986. This admission was preceded by Mr R being intoxicated with cannabis and outbursts of aggression. He was diagnosed to be suffering from a drug-induced psychosis. It was noted that he had recently returned from a family holiday in Jamaica. He was discharged after two months with further follow-up and antipsychotic medication.

In August 1986 Mr R was admitted to St John’s Hospital with hypomanic symptoms. He was verbally aggressive and was treated with a combination of medications. No details regarding the medications were reported. He was discharged in December

[1] The 1959 Mental Health Act was amended but not replaced in 1983

1986 and re-admitted shortly after with symptoms of depression. He was reporting hopelessness and poor sleep. He was discharged near the end of December to live with his parents.

In January 1987 Mr R was admitted to a hospital in London and then transferred to hospital in Aylesbury with hypomanic symptoms. He had been verbally aggressive and was not taking his medication. He was detained under section 3 of the MHA.

Mr R was admitted under MHA section 3 with hypomanic symptoms in February 1989. He was discharged with medication to stabilise his mood and manage his psychosis.

Mr R collapsed in Aylesbury town centre in December 1991. He went to the accident and emergency department (A&E) at the hospital and was admitted to the Tindal Centre in Aylesbury. The Tindal Centre is an inpatient facility and also the AOT base. He was overactive, had pressure of speech and was physically neglected. He was diagnosed with hypomania.

He was placed in independent housing later that year.

5.3 1993 to 2003

Mr R was admitted to the Tindal Centre for one month in February 1993. He was described in the notes as suffering from paranoid thoughts and flight of ideas (continuous flow of speech that jumps topic incoherently). He was not taking his medication and had used illicit substances.

Mr R was arrested under MHA section 136[1] by the police in February 1995. He had been evicted from his home due to debts.

Mr R was detained under the MHA and after treatment discharged to live in a group home in Aylesbury in May 1995. Later in the year he assaulted another resident at the group home. The incident was reported to the police.

Mr R was admitted to a hospital in London following an offence of assault occasioning actual bodily harm in October 1995. He had assaulted his employer and had apparently stopped taking his medication a week before the incident.

Mr R was in contact with the police on several occasions due to his behaviour between April and September 1996. Mr R's neighbours complained of loud music. He was verbally abusive and threatening to another resident at a group home, and was subsequently assaulted himself.

Mr R was violent and needed restraining by the police in November 1996. He was admitted to hospital under MHA section 2.

[1] Section 136 is used by the police to take members of the public to a place of safety if they have concerns about their mental health (http://www.legislation.gov.uk/ukpga/1983/20/section/136)

Between June and December 1997 Mr R was involved in violent incidents at the group home where he lived. Residents complained to social services about his disturbed behaviour. There is a record of one incident where he assaulted a girlfriend who had to go to A&E.

Mr R was admitted to Kimmeridge ward at the Tindal Centre in an agitated, hypomanic state in February 1998. He was detained under MHA Section 2. He had not been taking his medication and was using illegal substances.

In March 1998 Mr R was charged with disorderly conduct. He was described as mentally disordered with hypomanic symptoms while in police custody. He was taken home to his parents.

Mr R was admitted to Kimmeridge ward from the A&E department with police assistance under MHA Section 3 in August 1998. He had assaulted his partner and attempted to assault a nurse. Records show that prior to admission he had been drinking heavily and spending large amounts of money.

Mr R was evicted from the group home to bed and breakfast accommodation in January 1999. He was admitted to Kimmeridge ward again because he had not been taking his medication and was in a hypomanic state. While on the ward, Mr R assaulted a fellow patient who subsequently retaliated. He also went on overnight leave to his girlfriend's but was arrested following a serious assault on her. He was subsequently detained under MHA Section 3.

Mr R was convicted of grievous bodily harm and then detained under Section 37 of the MHA. Following this admission to hospital he was transferred to Bowden House secure unit from court. He was transferred back to the Tindal Centre and discharged to his own accommodation in Aylesbury in June 1999.

Mr R was admitted to hospital on an informal basis in December 2000. He was showing mild hypomanic symptoms and had been drinking heavily. During admission, he carried out an unprovoked attack on another patient who did not press charges. Mr R remained in hospital on an informal basis. He discharged himself but was re-admitted a few days later. Records show that while he was on the ward staff expressed concerns about his inappropriate sexual conduct with female patients on the ward. In view of this he was discharged.

Mr R was admitted informally to hospital in February 2001. He was hypomanic, had been drinking heavily and had not been taking his medication.

Mr R self-referred to hospital in August 2001. He was assessed and admitted for one week. Staff were concerned about his lack of his self-care. He had been drinking excessively and was presenting with possible hypomanic symptoms.

Mr R was admitted to hospital in October and November 2001. The circumstances of admission were similar to previous admissions.

Mr R was admitted to hospital twice due to a relapse of his mental state in January and March 2002.

Mr R pleaded guilty to possession of an offensive weapon in December 2002.

Mr R was transferred to the care of the AOT in February 2003. This was followed by a hospital admission.

In July 2003 Mr R assaulted a female member of staff at the reception of the Tindal Centre. He had been drinking excessively. The staff member did not want to press charges against him. He threw a full can of lager at a member of staff at the Tindal Centre during an outpatient appointment and hit another member of staff on the head. Attempts to press charges against him for the latter were not successful.

5.4 2004 until 2012

Mr R was not taking his medication in March 2004. He attended the AOT office and broke furniture. He was treated on a combination of olanzapine[1] and sodium valproate[2]. He was admitted to hospital. While there he was sexually disinhibited and inappropriately touched a female member of staff.

Mr R was convicted of theft and threatening to kill a neighbour in June 2005. He was bound over for three months.

Mr R was admitted to hospital twice during July and August 2005. He tried to assault two nurses. He was subsequently transferred to a psychiatric intensive care unit (PICU) where he remained until September.

Mr R was admitted to the PICU under MHA Section 3 in November 2005. During this admission, he openly smoked cannabis on the ward on several occasions. He was discharged in February 2006.

Mr R was assessed and admitted to hospital under MHA Section 3 in February 2007. During this admission he tried to attack two staff members by punching and kicking and he also attempted to assault a junior doctor. He hit a member of staff in the face, causing a wound that required several stitches. An attempt was made to discharge him under MHA Section 17 with support from the crisis team in December 2007. He was recalled to hospital and eventually appeared in court on a charge of actual bodily harm in January 2008. He received an 18-month community sentence, the conditions of which included probation and his medication being monitored by the AOT. During this period, he was also started on clozapine treatment.

Between 2008 and 2012, Mr R continued to be closely supervised by the AOT. During this time he remained out of hospital and was compliant with his medication

[1] Olanzapine is an antipsychotic used to treat schizophrenia (http://www.patient.co.uk/medicine/olanzapine)

[2] Sodium valproate is used to treat those with epilepsy or a bipolar disorder (http://www.nhs.uk/medicine-guides/pages/medicineoverview.aspx?condition=Mania%20and%20Bipolar%20Disorder&medicine=sodium%20valproate).

of clozapine and sodium valproate. His mental state remained stable although he suffered side effects from the medication.

5.5 2012 until the time of the incident

From January 2012 Mr R started to increase his alcohol use and was binge drinking. Staff began to be concerned about whether he was taking his medication.

On 16 January the visiting AOT social worker noted that there was a potential for Mr R to relapse because it was not clear if he was taking his medication.

Mr R was regularly seen by the AOT between January and March.

The AOT social worker noted on 13 April that Mr R was at risk of losing his tenancy (due to ongoing noise complaints) and at risk of relapse due to stress and possibly not taking his medication. On 27 April Mr R made threats to AOT staff that he would hit his neighbour with an iron bar because he had made comments about his medication (it is unclear if he threatened his neighbour in person). He later visited the AOT office and the police were called because he was verbally abusive to staff and they felt threatened. A MHA assessment took place at Mr R's home. The police were present. Mr R retracted his threats and he was not detained. An intensive community support package was agreed, including Mr R taking his medication in the presence of the crisis team.

In early May it was noted that Mr R was refusing to take his medication in the presence of the crisis team. It was agreed that the crisis team would no longer need to visit Mr R because he was not in acute crisis. He was discharged back to AOT on 8 May. AOT assumed responsibility of Mr R's medication management.

The AOT saw Mr R at regular intervals throughout May, although sometimes he was not home when they visited. At his Care Programme Approach (CPA) review on 28 May it was noted that Mr R had not taken his medication at one point for a week. Plans were put in place to change his medication. It was agreed that the AOT would notify all involved agencies if Mr R relapsed in the community.

During an AOT visit on the morning of 11 June it was noted that Mr R had been drinking. He admitted that he had drunk a lot over the weekend. At the clinical team meeting three days later it was agreed that Mr R was showing early warning signs and that he should continue to be monitored. Steps were taken to liaise with Mr R's GP with a view to changing his medication.

On 7 July 2012 the police were called to an altercation where Mr R had allegedly assaulted a female. Nobody came forward to complain of an assault so the matter was dropped.

A few days later on 13 July a social worker contacted the AOT to report that the client she had been visiting in the block where Mr R lived had voiced concerns about Mr R's behaviour and had called the police. The client also said that Mr R had been exposing himself on his balcony. The AOT visited Mr R that day. Mr R admitted that

he had been drinking alcohol more frequently. He drank during the visit. Mr R agreed to work with the crisis team (covering for the AOT when it was closed at the weekend) for a couple of weeks to ensure compliance with his medication. He agreed to reduce his alcohol intake. Mr R's management was overseen by the community acute service over the weekend. The AOT contacted the police about these incidents.

It was agreed at the AOT clinical team meeting on 19 July that Mr R should be referred for an MHA assessment if there were further incidents. A social worker visited Mr R the same day. She noted that he had not been taking his medication but he said that he had not been drinking. Mr R became angry and irritable during the visit. The social worker concluded that Mr R's mental health was gradually relapsing. Following a discussion with the team it was agreed Mr R should be referred for an MHA assessment.

An acquaintance of Mr R's contacted the AOT on 20 July to report concerns that Mr R's mental health was deteriorating. The acquaintance reported that he had witnessed Mr R shouting from his balcony window.

Mr R visited the AOT office the same day. He appeared hostile, agitated, was verbally aggressive and showed evidence of thought disorder. He then left. The AOT social worker contacted the police to tell them she was concerned there was a risk he would assault someone. There were concerns that Mr R was excessively abusing alcohol and cannabis. It was recorded in the notes that he had a history of poor compliance with medication. Additionally, it was noted that Mr R had appeared high, elated in mood and disinhibited in the previous week. It was agreed that Mr R should have a MHA assessment (he left before this could take place) with a view to considering whether he should be admitted.

AOT staff followed-up the next day with the emergency duty team on 21 July. The AOT social worker was told that a MHA assessment had not taken place because Mr R was missing. This had been reported to the police.

Mr R attended the Tindal Centre later the same day and asked to be admitted. AOT staff and members of the community acute team saw Mr R with the police. It was agreed he should be informally admitted and a full MHA assessment be undertaken.

Later the same day Mr R had a seizure due to alcohol intoxication. Mr R was taken to A&E. He was assessed by A&E staff who decided that he was medically fit and he returned to the ward. When he returned to the ward he told staff that he had drunk a bottle of rum.

While on the ward Mr R threatened members of staff and kicked the door when he was asked not to leave. He was subsequently detained under MHA Section 2 on 23 July. His leave was restricted.

In early August Mr R appealed against his MHA Section 2 to the mental health review tribunal but was unsuccessful.

On 8 August an MHA assessment was conducted by Dr1, AMHP and an independent S12 doctor. The assessment concluded that Mr R remained hypomanic and was a risk to himself and others. Mr R was subsequently detained under MHA Section 3.

Mr R's mood was variable throughout August, ranging from calm to hostile and aggressive. On 16 August it was recorded in the notes that Mr R presented as psychotic. It was agreed on 29 August that Mr R could start taking short periods of unescorted leave in addition to his escorted leave.

In September 2012, Dr1 was of the opinion that Mr R had made only a small improvement in his mental state and therefore she argued at a hearing for his continued detention under MHA section 3. The clinical team planned to discharge Mr R in the longer term under a CTO.

At the end of September a ward review took place. The clinical team decided to send Mr R on a trial of extended leave at home, attending day hospital three days a week and college for the other two days. He was supposed to attend the ward for his medication (which was all given at night) for the first week. Mr R did not comply with this and his behaviour at the day hospital meant that they refused to have him back. He was again verbally aggressive to staff. A new care coordinator was allocated with Mr R's agreement.

It was agreed on 27 September that Mr R should return to the ward with restricted leave (escorted and unescorted).

A MHA tribunal upheld Mr R's section on 12 October.

Extended MHA section 17 leave was tried again on 15 October, with medication initially being dispensed from the ward each evening. The risks were noted as excess alcohol consumption, aggression and fits (from alcohol withdrawal). Two weeks' leave was agreed in the first instance.

The AOT reviewed the plan on 2 November 2012. Mr R had missed one dose of medication from the ward, but the AOT had not been successful in getting him to engage with them again. The plan was that if Mr R did not engage with the current plan then the conditions of his leave would need to be reviewed alongside a potential recall to the ward.

Mr R started to miss appointments with the AOT and its staff were not able to contact him by phone. It was noted on 7 November that Mr R was not engaging but there were no beds available for recall. The clinicians agreed to extend the duration of dispensing Mr R's medication from the ward. However, from 9 November Mr R was treated in the community by the AOT delivering medication to him each day.

Mr R was scheduled to attend a meeting with Dr1 and the AOT social worker on 23 November to discuss a CTO. It is unclear if this meeting took place.

This plan went reasonably well, and the team decided to continue with it. The AOT made strenuous efforts to see Mr R over Christmas and the New Year but he did not

always engage. He was seen on 4 January in the communal entrance to his flat. He presented with positive mental health and stable affect. The AOT staff gave him three days medication. He was seen again on 7 January by the AOT social worker and Dr1. He refused to let them into his flat but spoke with them in the communal entrance. They gave him his medication and information about the CTO.

Mr R was seen again on 9 January at home. He appeared well and was reminded that he had a CPA review coming up. Later that day Mr R visited the team base in a distressed state. He was seen by members of the AOT and Dr1. He was intoxicated and worried about his ex-partner. Dr1 did not note any significant concerns.

Mr R visited the Tindal Centre on 10 January. He was seen by Dr1 who noted that he had pressured speech and anxiety. He was upset that his ex-partner had been assaulted and was worried about college exams. He said he was anxious and did not know what to do. He said he had not been taking his tablets properly and had missed them altogether the previous night. He asked for admission. Dr1 felt that Mr R had had a mild relapse but that recalling him from his leave was not necessary rather that the team would increase their contact with him and continue to manage him in the community.

Mr R visited the Tindal centre again the same day. He fell asleep in the waiting area. He was seen by AOT staff who contacted Dr1. Staff provided Mr R with food and drink, agreed a medication plan, and took him home. The incident was discussed at the team meeting later that day. It was agreed to increase input to daily for the forthcoming week and expedite the meeting to discuss the CTO.

Mr R was seen on 11 January 2013 by Dr1. Dr1 discussed the CTO with him. He was given medication for four days. Mr R's mental state gave no cause for concern – he appeared much better. He had taken extra medication the night before although he was advised not to. He would no longer agree to daily contact, but reluctantly agreed to a proposal of weekly contact with more if he became unwell. He agreed to a meeting after college on 16 January 2013 but did not attend the meeting. He was subsequently seen at home the same day and was given a week's medication. His speech was slightly fast and he appeared a little stressed. Another AOT appointment was made for 18 January.

Mr R would not initially allow AOT staff into his house on 18 January, saying he was decorating. Mr R appeared calm and his speech was normal. He eventually agreed that the AOT staff could go into his flat. Mr R was talkative and pleasant though it was noted that upcoming exams and issues around his disability living allowance (DLA) could increase his stress and impact on his mental health.

AOT staff visited on 22 January 2013, but ended the meeting because Mr R was threatening and verbally aggressive. He wanted to know why he was only being given four days of medication as opposed to a week. The AOT staff explained that not all of his medication had arrived in time to be delivered to him.

The team next tried to see Mr R on 25 January. Mr R's care coordinator and Dr1 visited Mr R at his home because they had been unable to contact him by phone. They reminded him to attend a planned CPA meeting later that day to finalise the

CTO, which he attended. He appeared irritable and elated during the meeting. He was unhappy that AOT staff had been making a number of attempts to see him. He was reluctant to agree to any ongoing regular contact from the AOT but wanted the team to help him if he had any problems. The CTO was due to commence on 4 February.

AOT staff saw Mr R briefly on 28 January to be given his medication. He was told that his medication order had not arrived and that the team would be back the following day to deliver more medication. He accepted this explanation.

AOT staff saw Mr R on 29 January to give him medication. He appeared pleasant in approach and at times appropriately humorous. He told AOT staff that his day at college had gone well but that he had had an argument with his tutor. The AOT staff helped Mr R add credit to his mobile phone for which he thanked them. The team confirmed that it would continue to see him twice a week.

The AOT did not see Mr R on 30 January. The team learnt the next day that he had been arrested on suspicion of causing life-threatening injuries to Mark Austin. Mark died in hospital on 1 February.

6. Issues arising

In the following sections of the report we provide our comment and analysis on the issues we have identified as part of our investigation into the care and treatment of Mr R. We have provided an extensive chronology of Mr R's care and treatment dating back to 1983; however, our analysis focuses primarily on Mr R's care from January 2012 up until the time of the incident.

The themes are:

- Mr R's diagnosis;
- risk assessment and risk management;
- forensic services;
- the care pathway;
- medication;
- long-term leave;
- CTO;
- Multi Agency Public Protection Arrangements (MAPPA); and
- predictability and preventability.

7. Diagnosis

Early in his psychiatric history Mr R suffered from a range of psychotic and hypomanic symptoms, and was initially diagnosed with drug-induced psychosis or a psychotic disorder.

Mr R's main diagnosis was bipolar affective disorder. This disorder is characterised by symptoms of hypomania such as elation of mood, agitation, restlessness, irritability, disinhibition, pressure of speech and flight of ideas. Mr R also experienced auditory hallucinations and paranoia. He was described as a pleasant and engaging man; however, his mood could change quickly and he could become physically and verbally aggressive.

Our clinical advisor reviewed Mr R's clinical notes. He commented:

> "While the diagnosis of a bipolar affective disorder is perfectly reasonable, and it certainly appears Mr R's presentation, when psychiatrically unwell, usually included hypomanic symptoms, I am of the opinion that a differential diagnosis of a schizoaffective psychosis could be entertained."

He went on to say of Mr R's diagnosis:

> "I am concerned by the opinion of the clinicians in charge of Mr R's care that he did not suffer from a personality disorder. The independent inquiry [trust inquiry] noted this was debated with the Assertive Outreach Team and they were clear in their opinion that Mr R did not suffer from a co-morbid personality disorder. I am of the opinion that Mr R did fulfil the criteria for the diagnosis of an antisocial personality disorder. In my opinion there was sufficient evidence to argue that Mr R had demonstrated features of this disorder and a pervasive pattern of disregard for and violation of the rights of others occurring since the age of 15..."

We discussed Mr R's diagnosis with Dr1, who was the AOT consultant psychiatrist at the time. It was Dr1's view that Mr R has a diagnosis of bipolar affective disorder.

In terms of considering Mr R's personality, Dr1 told us:

> "We were aware that [Mr R] had a difficult personality. How much of that was because of the fact that he had been consistently unwell, on and off, for a very, very long time, from quite a young age, and I think his illness affected the development of his personality to some degree. However, we saw big changes in [Mr R], dependent on his mental state – as you would expect in somebody who had this kind of disorder."

It was Dr1's view that the stabilisation of Mr R's mood and behaviour when receiving effective treatment for his mental disorder – as observed by the AOT – reduced the probability that Mr R was suffering from a personality disorder. She noted the complexity of making this type of diagnosis in the given situation.

7.1 Analysis

Our clinical advisor commented that the stabilisation of Mr R's behaviour when receiving treatment did not reduce the possibility that he was suffering from a personality disorder. He added that psychotropic medication plays a small role in the treatment of an antisocial personality disorder. Typically forensic psychiatrists would not use medication as a means of treating a patient with an antisocial personality disorder.

7.2 Finding

We conclude that Mr R's long-term diagnosis of a bipolar affective disorder did not change although there were indicators that he may have had an antisocial personality disorder.

8. Risk assessment and risk management

In this section we examine Mr R's forensic history and establish whether it was appropriately taken into account in the risk assessment and risk management process.

National policy requires that risk assessment and risk management should be at the heart of effective mental health practice. Risk management should be an integral aspect of CPA. The outcome of risk assessment should feed back into the overall clinical management.

National best practice guidance in managing risk in mental health services (DH 2007) sets out three risk factor categories. These are:

1. static factors: these are unchangeable, e.g., a history of child abuse or suicide attempts;
2. dynamic factors: factors that change over time, e.g., misuse of drugs or alcohol; and
3. acute factors or triggers: these change rapidly and their influence on the level of risk may be short-lived.

The trust has a clinical risk assessment and management policy (revised in 2010). The policy advises:

> "At a minimum, for people using trust services for long periods, a risk assessment should be undertaken yearly… the risk history should be initiated on all service users at assessment and updated as appropriate. If service users currently in care do not have a risk history it is the responsibility of the lead practitioner… to ensure that a risk history is compiled by those team members with the appropriate knowledge and experience."

The policy is framed against national policy:

- Care Quality Commission regulation 9;
- *National Suicide Prevent Strategy* (DH 2009);
- NHSLA Standard 4; and
- Best practice in managing risk.

Additionally, the reader is signposted to other trust policies, including the CPA, non-attendance for appointments and safeguarding vulnerable adults.

Mr R's risk notes contain a history of his risk incidents dating back to 1983. It documented incidents in which Mr R had been violent. From July 2012 up to the index offence in January 2013, there were five recorded instances of Mr R being aggressive or intimidating and one instance of him being sexually disinhibited.

It was recorded in his risk assessment progress notes in early September 2012 whilst an inpatient:

> "[Mr R]'s presentation indicated that his mental health continues to impact significantly on his ability to interact appropriately with others and remain focused on conversation… during this interaction, there were three staff members present and yet it was very difficult to manage the situation to prevent an escalation and manage risks."

In an updated psychiatric report on 7 September Dr1 wrote:

> "The overall impression is of a small improvement [on the ward] in his mental state but ongoing significant ill health… in my opinion [Mr R] continues to require detention under Section 3 of the Mental Health Act for his health and safety and for the protection of others."

On 20 October it was written in Mr R's notes that when on the ward:

> "[Mr R] was verbally abusive… dismissed staffs [sic] warning."

Mr R's progress notes were updated on 22 January 2013 after a home visit. It was recorded:

> "[Mr R] was threatening and aggressive today and we terminated the visit as we were unable to engage in conversation with him and due to the risk felt because of his presentation."

This information was added to Mr R's risk summary. It was recorded

> "22/01/13 during a routine AOT home visit, [Mr R] was verbally aggressive and intimidating towards AOT staff."

The AOT and the consultant psychiatrist made extensive efforts to assess and treat Mr R. Mr R was difficult to engage and at times could be aggressive and intimidating towards staff. The internal inquiry team and our clinical advisor noted that the AOT tried hard to work with Mr R to an extent that went beyond its remit.

Our clinical advisor had some concerns about the AOT's ability to assess the risk that Mr R presented:

> "He [Mr R] was very fortunate to have been treated by psychiatric professionals who knew him well and demonstrated a high level of commitment to him but I am concerned that meant they were somewhat willing to excuse his antisocial behaviour.
>
> "In my opinion the Assertive Outreach Team were too generous in the allowances they made for Mr R's antisocial behaviour and the effect his psychotic illness played in that, yet he continued to abuse them not infrequently while he was an inpatient."

We have previously explored Mr R's diagnosis and the possibility that he had an antisocial personality disorder. Any elements of an antisocial personality disorder would have increased the risk that Mr R posed to others.

Dr1 told us that when Mr R was an inpatient he was unwell with symptoms of hypomania which led to challenging behaviour towards inpatient and AOT staff. This decreased as his mental state improved.

Referring back to the diagnosis, our clinical advisor queried whether the team had explored a full range of possible diagnoses, reconsidering the diagnosis of a bipolar affective disorder alone and exploring a co-morbid personality disorder. He said:

> "In my opinion when a psychiatric team knows a patient well it is all too common for the same diagnostic formulation to be repeated during future contacts with the patient."

We asked Dr1 whether she considered that the AOT had underestimated the risk Mr R could pose to others. She told us that the team had considered this a great deal since the incident. She told us that she did not think that the team had underestimated the risk. She explained that although Mr R was well known and liked by the team he could still be difficult and he wasn't easy to manage. Dr1 said:

> "You make an assumption that your risk assessment was wrong, because if your risk assessment wasn't wrong, this [the incident] wouldn't have happened, but that isn't actually how risk assessment works… No, I don't think so [that the team underestimated Mr R's risk]."

Dr1 went on to say:

> "We were all fond of [Mr R], but he wasn't an easy person."

We were told that Mr R was more compliant when subject to a probation order in 2008 and that he adhered to the conditions of the order. Dr1 told us:

> "The best time I think that we had with [Mr R] was when he was on clozapine, and when he was probably subject to the probation order with a condition of treatment, the community treatment order."

Mr R's compliance with his treatment plan was variable. He also drank regularly and was known to smoke cannabis. Taking this into account our clinical advisor said in terms of Mr R's general care:

> "… given his [Mr R's] history of variable compliance and the risk he was thought to pose to others, more efforts should have been made to impose this treatment on him."

8.1 Analysis

We note that the team knew Mr R well. He was generally liked and this familiarity may have clouded the team's ability to judge the real risk that Mr R could present. We note, however, that the AOT staff told us they would only visit him in pairs for safety reasons.

Mr R's clinical records did not wholly reflect his forensic history and we do not believe that the team was fully aware of the true extent of his violent behaviour. Dr1 did not agree with our assessment. However, it is our opinion that it is not clear that all AOT staff, at all times, were aware of Mr R's risk history, and in particular what violence he was said to have been involved in. We discuss this further under 'Forensic services'.

We are unclear whether this gap in knowledge was a result of the team being over-optimistic about its ability to manage Mr R or that it underestimated the risk he could pose. We note the extensive work of the team to engage with Mr R, but believe that it would have been helpful for the team to speak to other agencies such as the police to build up a more accurate risk profile.

Dr 1 told us that she believed the team had active contact with the police in the period prior to Mr R's last admission. There is evidence that the AOT engaged with the police when it had concerns about Mr R or needed help in managing him. For example, in April 2012 the police were contacted when staff at the Tindal Centre felt threatened by Mr R. In July 2012 the team contacted the police in relation to concerns about Mr R's behaviour. We did not see evidence of collaborative dialogue with the police in terms of building up a risk profile.

We were impressed by Dr1's thorough and measured approach to our questions. She was very familiar with Mr R's case and provided clear clinical reasons for the decisions made by the team which we felt stood up to scrutiny.

8.2 Findings

The AOT and consultant psychiatrist made extensive efforts to engage, assess and manage Mr R.

Mr R's risk was considered seriously by the AOT but they made too many allowances for Mr R's antisocial behaviour, underestimating the indicators that he possibly had an antisocial personality disorder.

9. Forensic services

Mr R was not referred to forensic services for assessment. The notes we reviewed did not indicate whether seeking a forensic opinion had been considered.

We asked Dr1 whether the team had considered referring Mr R to forensic services. She told us that they were not in touch with forensic services prior to the incident. She did not think that a forensic assessment would have led to a change in treatment given that the team was considering a community treatment order. Mr R was on section 3 and there were no outstanding criminal justice issues. She did not think the forensic team would have thought a referral appropriate in 2012, although it had been involved in the past.

The trust internal investigation stated:

> "It is difficult to see what would have been gained by a referral to forensic services. [Mr R] would not have been eligible to receive a service from them prior to 31 January 2013, and a forensic opinion is unlikely to have added anything to either the risk management plan or the understanding of the patient, both of which had been honed over many years through constant experience of working with him."

However, our clinical advisor disagreed with this point, arguing that the AOT's familiarity and constant experience of working with Mr R:

> "…warranted Mr R being referred for a forensic psychiatric opinion."

Our clinical advisor was critical of the documenting of Mr R's forensic history, saying:

> "It is difficult to know, certainly with any accuracy or confidence, exactly what criminal convictions cautions Mr R received. It is important to document exactly what a patient is convicted of, the circumstances of the offences and what sentence the person received from the court. In my opinion this is important for a number of reasons. Allegations which have not led to a criminal conviction are often challenged by patients and their legal representatives. The quality of risk assessments is highly dependent on accurate information."

Dr1 disagreed with this assessment commenting that she felt there was a good level of recording information.

Our clinical advisor believed it would have been beneficial to refer Mr R to a forensic psychiatrist:

> "I am of the opinion that it would have been entirely reasonable to refer Mr R, given his actual forensic history and the risks he was perceived to present to others, for a forensic psychiatric opinion… The internal inquiry were of the opinion a referral would have added little to his care but… at the very least it would have allowed a clinician experienced in dealing with patients with a forensic history and presenting a significant risk to others, to review Mr R, his

> diagnoses and the care he received…. This might well have resulted in recommendations being made that if at all possible use of the criminal justice system should be made and Mr R should be treated with an injectable form of antipsychotic medication."

The trust has a Forensic Community Mental Health Team (FCMHT) which it describes as providing:

> "… specialist psychological and psychiatric interventions to assess, treat and manage individuals who, as a consequence of mental illness or personality disorder, have offended or present a potential to offend and therefore pose a risk to themselves or others. The aim of the intervention is to maintain and improve mental health, improve the quality of life of service users, and manage the risk of violence or other re-offending."

9.1 Analysis

Examples of the use of the criminal justice system include the option of referring Mr R to MAPPA (we discuss this further under 'MAPPA'), encouraging the police to prosecute alleged criminal offences (as opposed to accepting an admission) and the subsequent consideration of a restriction order. In July 2012 there were allegations that Mr R had assaulted someone and, separately, exposed himself. The police attended the scene of the assault however no one came forward and the matter was dropped. AOT contacted the police about both incidents however there is no evidence to suggest that the team encouraged the police to purse the allegations with a view to prosecuting Mr R. It is acknowledged that there is no guarantee that any of these options would have been suitable for Mr R at the time however it would have been appropriate for the AOT to explore the full breadth of options available to it.

It would have been helpful to refer Mr R to the FCMHT. Regardless of whether Mr R met the criteria for care by the forensic services, advice about his management might have been helpful.

9.2 Finding

Mr R should have been referred to forensic services for assessment and advice about his management.

9.3 Recommendation:

When service users have an extensive forensic history and present a significant risk to others, consideration should be given to referring for a forensic psychiatric opinion.

10. Care pathway

The trust has a CPA policy (2010) that outlines four components: systematic assessments of mental, physical and social care needs and risk; a care coordinator; a written care plan and regular review. It advises that CPA should be applied to patients requiring long-term care or contact from more than one member of staff.

The policy is supplemented by appendices that detail the CPA procedure (e.g., recording CPA, the assessment process, safety and risk assessment and management, the care plan, and the role of the care coordinator).

Mr R met the criteria for CPA. He had a care coordinator and a care plan which was kept up to date. The care plan explored Mr R's mental health and physical needs. It also highlighted his drug and alcohol use.

Mr R was placed on an unrestricted hospital order[1] in 1999 after he was said to have assaulted another patient and seriously assaulted his girlfriend when on leave from hospital. He was subsequently convicted of grievous bodily harm. Our clinical advisor commented that it would not be an exaggeration to suggest that Mr R could have been subject to another restricted hospital order prior to the index offence in 2013. Mr R assaulted two members of staff in 2007, and was found guilty of wounding and actual bodily harm in 2008, for which he received an 18-month community rehabilitation order.

Our clinical advisor described the efforts of the AOT to engage Mr R in his treatment plan as impressive and we would concur with this. However, Mr R's care pathway was heavily reliant on his compliance with medication. Our clinical advisor commented:

> "… the treatment and care Mr R received during 2012 had been determined by the pattern that had been set over a number of years. The pharmacological treatment plan had to undergo major changes when Mr R refused to continue the clozapine in 2011 and it would appear his mental state was never stable again, despite a period of inpatient care and presumably better compliance with treatment recommendations."

The AOT told us Mr R responded well to clozapine; however, he experienced a variety of side effects (excessive salivation and significant urinary retention) and did not wish to take it, which is why it was stopped.

10.1 Analysis

There were various means by which the AOT could have explored imposing treatment on Mr R, such as depot injections or a CTO, although these would admittedly be reliant on Mr R's compliance and engagement. These were considered by the AOT in the latter part of 2012. We discuss this in greater depth under

[1] A form of criminal restriction when there has not been a trial; the patient is detained on the understanding that he or she may be sent to prison

'Medication' and 'CTO' respectively. Alternatively, seeking a forensic psychiatric opinion, referring to the community forensic psychiatric team and/or requesting further involvement by the criminal justice system could all have been explored.

Our clinical advisor concluded:

> "… it was not the lack of engagement that the assertive outreach team sought to have with Mr R that was wanting, but better use of mental health law and the legal remedies that could have been available to the treating team which might have made a significant difference to Mr R's care and the risk he presented to others."

10.2 Finding

The AOT consistently attempted to engage with Mr R; however, they did not comprehensively explore alternative options such as mental health law and legal remedies when Mr R was non-compliant.

10.3 Drug and alcohol use

We considered Mr R's drug and alcohol use and whether this should have featured as part of his care plan. It was known historically that Mr R would use alcohol and smoke cannabis. The AOT staff told us that Mr R could be challenging if he had been drinking. Mr R's inpatient care plan in 2012 considered drug and substance misuse. The goal was:

> "…for [Mr R] to abstain from drug and alcohol… For [Mr R] to develop insight into the effects of drugs and alcohol on his mental health."

It was recorded that a key nurse would carry out an assessment of Mr R with a view to considering whether he should engage in group or individual session with the substance misuse team. The entry was dated 10 September 2012 with a completion date of 7 November.

It was recorded in Mr R's notes on 10 September:

> "…to discuss drug and alcohol misuse when [Mr R] is better."

It was recorded in Mr R's notes that drug and alcohol misuse was a risk. When Mr R was recalled to the ward on 27 September it was noted that he had been drinking. It was noted on 9 and 14 October that Mr R returned to the ward after unescorted leave smelling of alcohol. There is no evidence in the notes to indicate that Mr R was assessed for engagement with the substance misuse team prior to going on long term leave on 15 October 2012.

We reviewed Mr R's notes to see if alcohol or drug taking featured in the months leading to the incident in January 2013. Between 15 October 2012 (when he went on long-term Section 17 leave) until the incident there were three occasions when

AOT staff recorded that it was suspected/known he had been drinking; 15 October,19 December 2012 and 9 January 2013. There is no other evidence in the notes that Mr R was using alcohol or smoking cannabis. This is not to suggest that he was not using drugs and alcohol (we have no way of knowing this). He was being seen regularly by the team and other than the occasions recorded above there is no other evidence of use of drugs and alcohol recorded during that period.

11. Medication

Mr R was treated with a variety of antipsychotic drugs and mood stabilisers in the past 30 years. These included haloperidol[1], olanzapine, clozapine, carbamazepine[2] and sodium valproate. Mr R was typically treated with antipsychotic medication.

It was widely acknowledged that Mr R's mental health improved considerably when he started taking clozapine in 2008. Mr R's parents and Dr1 commented on the side effects experienced by Mr R and the fact that he did not wish to take clozapine because of them. He stopped taking it in 2011. Dr1 told us that she had discussed with Mr R the prospect of taking clozapine again but that the side effects he had experienced were distressing for him. These included hyper-salivation and urinary problems. She said:

> "I was probably a stuck needle talking to [Mr R] whether he'd consider going back on to it but they weren't made-up side effects. He did have proper problems."

Dr1 told us that the team tried to support Mr R to have his urinary problems investigated by his GP, but he was reluctant to allow an examination. Dr1 told us that she discussed with Mr R many times how his GP might be able to offer treatment for his urinary problems which in turn would improve his health and might have allowed clozapine to be reconsidered.

It is well documented that the team regularly saw Mr R to give him his medication and that at one point a condition of his long-term leave was to receive his medication on the ward so that it could be monitored.

The trust internal report noted:

> "Olanzapine seems to have been better at helping him to sleep (and if he did not sleep other risks increased) but otherwise neither [risperidone[3]] drug was as good as clozapine in controlling his symptoms."

In the months preceding the incident in January 2013 Mr R was prescribed olanzapine, sodium valproate and zopiclone[4].

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[1] Halpoeridol is an antipsychotic used to treat a number of conditions including schizophrenia. It is used to treat symptoms of aggression and agitation (http://www.nhs.uk/medicine-guides/pages/MedicineOverview.aspx?condition=Aggression,%20Restlessness%20and%20Agitation&medicine=Haloperidol)

[2] Carbamezepine is used to treat epilepsy and bipolar disorders (http://www.nhs.uk/medicine-guides/pages/MedicineOverview.aspx?condition=Mood%20Disorders&medicine=Carbamazepine)

[3] Risperidone is an antipsychotic typically used to treat schizophrenia (http://www.patient.co.uk/medicine/risperidone-risperdal)

[4] Zopiclone is used to treat insomnia (http://www.nhs.uk/medicine-guides/pages/MedicineOverview.aspx?condition=Insomnia&medicine=zopiclone&preparationZopiclone%203.75mg%20tablets)

Dr1 told us:

> *"*The olanzapine was working reasonably well for him with the mood stabilisers.*"*

We were told by former AOT staff that consideration had been given to changing Mr R's treatment. Dr1 told us:

> "We were beginning to have discussions between ourselves about depot medication but there were particular problems with [Mr R] because he'd had conventional depots in the past and had suffered dystonic reactions[1] and would have very, very severe side effects. He'd then been on the clozapine but had stopped it again because of the side effects."

Dr1 told us that consideration was being given to the use of depot olanzapine; however, she said:

> *"*I don't think as an organisation we'd used it very much at all and it was during the period of Section 17 leave when we were beginning to wonder if we couldn't sustain the amount of input that we were giving to [Mr R], whether we could consider trying it. There were, again, a lot of problems because if you give someone depot olanzapine you have to observe them for several hours for ever after every dose.*"*

Dr1 explained that this was because of the unusual side effect of hypersedation and that the licence for the depot olanzapine stipulates that patients be observed in a health care setting for three hours after every dose.

Dr1 added:

> "I, personally, hadn't prescribed it [depot olanzapine] for anyone at that point, and we were aware of the whole issue around having to monitor him for many hours afterwards, and we knew how difficult that was going to be with [Mr R], because he was so determined to live independently, and not have to engage with us for any longer than he needed."

Dr1 told us that the team had not stopped considering the use of depot olanzapine.

11.1 Analysis

A condition of the CTO that was being considered for Mr R included compliance with psychotropic medication. There is no guarantee that Mr R would have complied with this condition, although it had been noted that he met the conditions of a previous probation order in 2008 which included medication. We discuss this further under 'CTO'. The team was aware that Mr R responded well to clozapine but accepted the reasons behind his reluctance to take it (the side effects he experienced). As a result the AOT sought alternative options for him. The team had considered the use of

[1] Uncontrollable muscle contractions

depot olanzapine, but again there was a general assumption that Mr R would not comply with the conditions, particularly in relation to lengthy periods of observation.

11.2 Finding

Mr R responded well to clozapine but the side effects were considerable and in 2011 he refused to continue taking it.

12. Mr R's long-term leave

Mr R was admitted under MHA Section 2 in July 2012. He remained under that section until September 2012 when it was converted to MHA Section 3. In September Mr R was allowed to take short periods of escorted and unescorted leave. Towards the end of September it was agreed that Mr R could engage in a trial of extended MHA Section 17 leave while continuing to attend the ward for his medication. This began on 24 September.

This did not work. Mr R did not comply with the conditions of his leave and he was verbally aggressive to staff. He returned to the ward on 27 September.

The next month, another extended MHA Section 17 was put in place with conditions around Mr R's leave. This began on 15 October.

The AOT noted on 7 November that Mr R was not engaging and consideration was given to recalling him however there no beds available on the ward on that day. The team continued to manage him in the community.

Mr R remained on leave until the offence in January 2013. During this period his compliance with the conditions of his leave was variable. Dr1 told us that the team was using the extended leave to test whether a CTO would be appropriate for Mr R.

12.1 Analysis

The AOT took active steps to engage with Mr R when he failed to comply with the conditions of his leave. The lack of an inpatient bed in November reduced the team's options; however, a meeting was arranged with the ward manager and Mr R was seen the next day by the AOT to discuss his weekly plan. The AOT did not feel the need to recall Mr R to the ward again.

13. Community treatment order

In this section we explore the team's consideration of the use of a CTO as a means of managing Mr R.

The AOT told us that Mr R had been easiest to manage when he was subject to a community probation order in 2008, the conditions for which included his medication being monitored by the team. They told us that it took extensive effort to work through the criminal justice system to get the probation order put in place. They told us that in 2012 they gave detailed consideration to using a CTO to help manage Mr R.

The AOT told us that extensive thought had been given to implementing a CTO but that it had taken considerable time to come to fruition. They explained that in the first instance Mr R had to be detained before it could be considered. Mr R was detained from July 2012 until he was placed on long-term leave, briefly in September 2012 and substantively from October 2012.

The updated psychiatric report written by Dr1 on 7 September notes:

> "It is likely we will consider in the longer term whether a Community Treatment Order may be appropriate, given the major problems with compliance that contributed to [Mr R's] admission and have been a feature of his illness for the 18 months since he stopped clozapine and intermittently before that time."

In mid-September 2012 the AOT considered whether Mr R could be discharged under a CTO. However, it was understood that Mr R did not like this idea and did not want staff visiting his home. Despite this, a discharge under a CTO continued to be discussed by the team. Dr1 and an AOT social worker were scheduled to see Mr R on 23 November to discuss the CTO (there is no further information about this, although it is written in the notes on 29 November that Mr R *"*needs to meet with [Dr1] and [the AOT social worker] to plan for a reduction in visits"). In January 2013 the team was taking steps to arrange a meeting to discharge Mr R on a CTO.

On 10 January Mr R was seen in a distressed state by the AOT consultant psychiatrist. It was recorded in his notes: "Need to refer urgently now or meeting to consider CTO". Mr R was seen the next day by Dr1 who noted Mr R was better. It was agreed that steps would be taken to arrange the CTO "asap". Dr1 contacted the AMHP office with a view to arranging an MHA assessment for CTO prior to Mr R's section 3 expiring on 7 February. She also wrote to Mr R's GP to report Mr R's distressed state the previous day and the team's intention to place him on a CTO.

13.1 Comment

We note that Dr1 was actively engaging with other services to proceed with the CTO and kept Mr R's GP informed.

A CPA review took place on 25 January 2013. During this meeting CTO was again discussed with Mr R and it was recorded in the progress notes that he was happy to proceed.

It was agreed that a CTO would begin on 4 February 2013. The conditions of the CTO were that Mr R should take his medication as prescribed, comply with the agreed care plan and engage with the AOT, including clinical members of the team. Dr1 told us that depot medication was not to be a condition of the order because it had not been tried before.

Dr1 also told us that there are no requirements in the conditions of a CTO to specify particular medications, the dose or the method of administration. These issues can be covered by second opinion appointed doctor or responsible clinician, and can be varied after the initiation of the CTO.

In summary, the chronology of events leading to the CTO was:

- Mr R was informally admitted to Kimmeridge ward on 21 July;
- Mr R was detained under section 3 of the MHA on 23 July;
- Dr1 wrote in an updated psychiatric report dated 7 September that a CTO was being considered for the long-term management of Mr R;
- a trial of extended leave began on 24 September;
- Mr R was recalled to the ward on 27 September;
- Mr R went on long-term leave on 15 October;
- Mr R was described on 7 November as not engaging but a bed was not available for his recall;
- Dr1 contacted the AMHP office on 11 January to arrange an MHA assessment for the CTO; and
- it was intended that the CTO would be implemented on 4 February, three days before Mr R's Section 3 expired.

Dr1 told us that Mr R's MHA Section 17 leave was being used to test the feasibility of whether a CTO would work for him. She explained that the team was familiar with the use of CTO, and that a number of patients were under CTOs at the time Mr R was being considered. In particular, the team was exploring how to manage Mr R under a CTO and the means by which he would be taken off it. She told us:

> "I, personally, had at that point put more patients on CTO than anybody else in the county, because I was working with the Assertive Outreach Team that had patients who were going to be put on [to CTOs]. We had experience in managing CTOs. We also felt we shouldn't be putting somebody on a CTO unless we could talk to them about their route out of CTO, because that was clearly a very contentious, legal issue…. When we were looking at CTOs, we wanted to be able to set people goals to achieve [in order] to come off it [the CTO]. We weren't at that point with [Mr R], so we were trying to work towards some kind of point where we could talk to him about a CTO, [at which point] we could say what the conditions were going to be, and tell him what the expectations of him were going to be, if he wanted to come off it [the CTO] again."

Our clinical advisor agreed that CTOs are a difficult issue for psychiatrists, and noted that they only came into operation in 2008 and have been one of the most contentious parts of the MHA 2007. The use of CTOs varies across and sometimes within trusts. Our clinical advisor added that he thought the team's plan to test Mr R's cooperation was reasonable.

13.2 Analysis

There were no guarantees that Mr R would agree to the conditions of his CTO. However, historically the team had found Mr R to be most compliant and respectful of boundaries in 2008 when subject to a community probation order. On this basis it was appropriate to be considering not only the CTO but also the steps beyond it. The team told us that it would have liked to implement the CTO sooner but that Mr R was not in a position to participate effectively in the process of a CTO until late 2012 and early 2013.

13.3 Finding

We agree that the option of using a CTO for Mr R was appropriate.

14. Multi Agency Public Protection Arrangements (MAPPA)

MAPPA arrangements manage the risk posed by the most serious sexual and violent offenders. The police, probation and prison services and other agencies are brought together to share information so that risk assessments and risk management plans can be put in place.

There are three categories[1] of offender under MAPPA criteria:

- "Category 1 – Registered sexual offender.
- Category 2 – Murderer or offender who has been convicted under Schedule 15 of the Criminal Justice Act and:
    - who has been sentenced to 12 months or more in custody; or
    - who has been sentenced to 12 months or more in custody and is transferred to hospital under s.47/s.49 of the MHA 1983; or
    - who is detained in hospital under s.37 of the MHA 1983 with or without a restriction order under s.41 of that Act.
- Category 3 – Other dangerous offender: a person who has been cautioned for or convicted of an offence which indicates that he or she is capable of causing serious harm and which requires multi-agency management. This might not be for an offence under Sch.15 of the CJA 2003."

Mr R had criminal convictions. In 2007 he was charged with actual bodily harm and received an 18-month community sentence with conditions. It is not recorded in Mr R's notes whether the community order had any psychiatric conditions attached to it. The known conditions were attendance at probation and that the AOT monitor his compliance with medication. Mr R had a known history of violence and intimidating behaviour.

We wrote to the police to discuss whether Mr R had been considered at any point for MAPPA. We were told that Mr R was in MAPPA from 6 March 2008 until 6 June 2009 as a category 3 level 2 case. He had been referred to MAPPA after he attacked a worker at the Tindal Centre which resulted in a minor injury. Mr R was subsequently an archived case on ViSOR[2]. Dr1 told us that she and Mr R's care coordinator attended MAPPA meetings during this time until Mr R was discharged from MAPPA.

There were four[3] instances between April and July 2012 of Mr R being verbally aggressive or threatening to neighbours and staff which culminated in his admission in July 2012. The AOT reported the incidents to the police.

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[1] http://www.justice.gov.uk/downloads/offenders/mappa/mappa-guidance-2012-part1.pdf

[2] ViSOR is essentially a database of MAPPA cases. Offender information can be archived and reactivated if required. It can be accessed by the police, probation and prison services (http://www.justice.gov.uk/downloads/offenders/mappa/mappa-guidance-2012-part1.pdf)

[3] We note that on one occasion Mr R made a threat about his neighbour to the AOT staff – we do not know if he threatened the neighbour in person.

We found nothing in Mr R's notes to indicate that he had been considered more recently for MAPPA. In the 12 months leading to the incident he was aggressive and threatening but was not charged with criminal activity.

Our clinical advisor commented that had MAPPA been involved it is much more likely that Mr R would have been prosecuted for alleged offences when in the event no further action was taken.

14.1 Analysis

Although Mr R had not been charged with criminal activity in the months leading up to the incident on 30 January 2012, we believe that there would have been value in the team considering a referral to MAPPA. Although there is no guarantee that Mr R would have been accepted, he had been subject to MAPPA conditions historically and referral at this juncture may have opened a dialogue between health care professionals, the police and probation services. Dr1 reviewed the notes and confirmed that Mr R was not referred to MAPPA again after his discharge from MAPPA in 2009.

15. Predictability and preventability

The terms of reference for this investigation ask us to identify whether there were any aspects of the care which could have been altered or prevented the incident from happening. We use two definitions to help us assess predictability and preventability.

15.1 Predictability

15.1.1 Our definition of predictability

We consider that the homicide would have been predictable if there had been evidence from Mr R's words, actions or behaviour at the time that could have alerted professionals that he might become violent imminently, even if this evidence had been unnoticed or misunderstood at the time it occurred.

15.1.2 Comment and analysis

We looked at the AOT notes detailing its contact with Mr R in the weeks leading up to the incident on 30 January 2013. Between 1 and 31 December 2012 the team regularly saw Mr R to give him his medication. During this period the team reported nothing untoward other than that Mr R was at times reticent and reluctant to engage in conversation.

Nothing untoward was reported during the first week of January after which:

- on 9 January Mr R attended the Tindal Centre. He was intoxicated and worried about an ex-partner;
- on 10 January Mr R attended the Tindal Centre in a distressed and talkative state. He wanted to be admitted. The AOT consultant psychiatrist felt he had anxiety and a mild manic relapse and that the team should increase their support of him in the community;
- later the same day Mr R returned to the Tindal Centre and fell asleep in the waiting area. The team felt that Mr R was mentally stable but exhausted. Mr R was taken home;
- on 18 January Mr R was noted to be fine but had upcoming exams and issues with the disability living allowance (DLA) that could increase his stress;
- on 22 January Mr R was noted to be threatening during a home visit;
- on 25 January Mr R appeared irritable and elated during his CPA meeting; and
- on 29 January Mr R told AOT staff that he'd had an argument with his college tutor. He was pleasant in approach and thanked the AOT support worker for helping him put money on his mobile phone account. No new risks were identified.

Though Mr R was threatening on 22 January this was not of a degree that indicated to AOT staff that Mr R was going to become imminently violent. Historically there had been occasions when he was threatening to staff without this leading to actual

violence and this event was not significantly different. It was known to the team that his behaviour could be unpredictable. The AOT considered in November 2012 whether they should recall Mr R. A bed was not available and plans were made to manage Mr R in the community where he gradually settled. Mr R had not voiced any explicit threats towards others during December or January, nor was there any evidence that he had been violent towards others or destructive of property.

The trust internal investigation commented:

> "Overall, the 10 years of work that the AOT had invested in the care of Mr R should be considered a success. Without the dedicated input of mental health professionals, we judge it likely that a serious incident would have happened, probably impulsively, earlier in his psychiatric career."

Out expert advisor commented:

> "… risk assessment in psychiatry should be broken down into immediate risks, risks within a relatively short period of time and risks in the longer term…"

Based on Mr R's psychiatric and forensic history we conclude that it could reasonably be predicted that Mr R may be violent at some time but the degree of that violence was unknown. However it was not possible for AOT staff to predict in January 2013 that Mr R would be imminently violent or the level of this violence.

15.2 Preventability

15.2.1 Our definition of preventability

We consider that the homicide would have been preventable if professionals had the knowledge, the legal means and the opportunity to stop the violent incident from occurring but didn't take steps to do so. Simply establishing that there were actions that could have been taken would not provide evidence of preventability, since there are always things that could have been done to prevent any tragedy.

15.2.2 Comment and analysis

In the weeks leading to the offence on 30 January 2013 Mr R gave no indications to the AOT that he would be imminently violent.

In January 2013 Mr R did not voice any intention to harm others and it was felt that Mr R could continue to be managed while on leave but with more support. He attended the Tindal Centre on 10 January 2013 in a distressed state and wishing to be admitted. Dr1 considered this to be because he was worried about an ex-partner. Historically his previous request to be admitted in July 2012 had been agreed, however at that time he was notably aggressive and agitated and the team had been increasingly concerned about his mental state in the preceding week. On 10 January Dr1 considered that Mr R had experienced a mild relapse and that the

AOT could continue to manage him in the community. Dr1 did not believe that Mr R needed to be admitted. Mr R was notably calmer when seen by Dr1 the next day. Mr R was threatening on 22 January however staff had experienced this behaviour before and it did not give staff cause to consider that he be admitted. The MHA code of practice makes it clear that several factors should be considered in deciding whether patients should be detained for their own health and safety and the protection of others. Two of those factors are:

- "the reliability of the available evidence, including any relevant details of the patient's clinical history and past behaviour, such as contact with other agencies and (where relevant) criminal convictions and cautions;
- Whether other methods of managing the risk are available."

There is no indication on this occasion that Mr R met the criteria for detention under the MHA. The team believed that it was managing Mr R's risk and there was no evidence in the notes to suggest that he posed an imminent risk to others. Our clinical advisor commented:

> "There were concerns about his mental state, there should have been concerns about the risks he presented to others given his history and his compliance with treatment recommendations [that] could not be properly assessed. Against this… they [AOT] had a reasonable therapeutic relationship with Mr R… he had acted like this many times before and they were able to contain it…"

Our clinical advisor added that the MHA cannot be used every time a patient refuses to engage with staff and that it was reasonable for the team to have let the situation run at the time and attempt to use their skills to address it. A level of risk is inherent in managing patients in the community. The aim of mental health services is to manage patients in the community where possible provided they have been assessed as not posing a significant risk to themselves or others. When Mr R was seen on 29 January he appeared calm and did not give staff cause for concern.

We found that Mr R's presentation during the week preceding the incident provided insufficient grounds for the AOT to arrange a MHA assessment with a view to admission.

Based on the above we conclude that it was not possible for AOT staff to have prevented the death of Mark Austin.

16. The trust internal investigation and progress made against the recommendations

In this section we examine the trust's incident policy and whether the investigation into the care and treatment of Mr R met the requirements set out therein. We have reviewed the trust's serious incident investigation policy. Trust policy states that an investigation should take place when there has been a serious incident.

The terms of reference for this investigation include assessing the quality of the internal investigation and reviewing the trust's progress in implementing the action plan.

16.1 National guidance

The National Patient Safety Agency (NPSA) good practice guidance *Independent investigation of serious patient safety incidents in mental health services*[1] (2008) outlines three steps in the independent investigation process, two of which are the responsibility of the trust. These are to undertake an initial review within 72 hours of the incident being learnt of, and to complete an internal investigation using RCA.

The NPSA produced *Root cause analysis investigation tools - three levels of RCA guidance*[2] (2008). It lists three levels of RCA and states that a level 2 (comprehensive investigation) should be:

> "commonly conducted for actual or potential 'severe harm or death' outcomes from incidents, claims, complaints or concerns."

It further states that the investigation should use:

> "appropriate analytical tools (e.g., tabular timeline, contributory factors framework, change analysis, barrier analysis)"

and that it is:

> "normally conducted by a multidisciplinary team, or involves experts/expert opinion/independent advice or specialist investigator(s). Conducted by staff not involved in the incident, locality or directorate in which it occurred."

[1] http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=60156
[2] http://www.google.co.uk/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0CCIQFjAA&url=http%3A%2F%2Fwww.nrls.npsa.nhs.uk%2FEasySiteWeb%2Fgetresource.axd%3FAssetID%3D60179%26type%3Dfull%26servicetype%3DAttachment&ei=GKGhU7PIL6bb7AbHh4CICQ&usg=AFQjCNHXQ1YT4wXj5I6DZBob2r7mBkrTCg&bvm=bv.69137298,d.ZGU

16.2 Trust policy

The trust has a policy and procedure for the reporting and management of incidents, including serious incidents requiring investigation (SIRI) (2012). The aims of this policy include:

- to enable the trust to analyse incident trends, root causes, costs and develop appropriate action plans to eliminate or minimise exposure to associated risks;
- to enable staff to participate, and effect change, by ensuring that learning from incidents occurs and that resulting changes in care, policy or procedures are embedded in local practice; and
- to provide formal documentation to assist in managing complaints, claims and investigations by statutory bodies and to ensure compliance with external regulatory bodies, i.e., NHS LA Risk Management Standards, and Care Quality Commission Registration.

The policy provides checklists for staff with different responsibilities to work against. In line with NPSA good practice guidance it outlines that serious incidents should have an initial review within 72 hours. It sets a six-week time frame against which a (draft) RCA investigation should be submitted.

16.3 Detection of the incident

The AOT was informed by the AMHP service on the morning of 31 January that Mr R had been arrested for “intent to cause harm”/GBH in the early hours of the morning. The team learnt on 1 February that Mark Austin had died in hospital.

16.4 Initial investigation report

The trust completed an initial investigation on 1 February 2013. The report detailed:

- immediate actions taken after the incident;
- chronology of recent events leading up to the incident;
- other information relevant to the incident;
- care arrangements and risk assessment/management plans at the time of the incident; and
- Mr R’s medication.

The report did not identify any immediate areas of concern, but recommended:

> “service managers and other relevant staff to be aware of the need to escalate the securing of a forensic bed to the appropriate clinical director.”

In order to achieve this it was actioned:

> "communication brief to be sent out to all staff reminding them of the correct pathway and process for establishing a bed within the forensic directorate."

The clinical director for the adult mental health directorate was tasked with completing the action by April 2013. We asked him about completing this action. He told us that although he was unable to recall the exact action around this he was confident he would have suggested that the action was not appropriate. He explained that forensic beds are commissioned by specialist commissioners and that specific gateway assessments are required – they are not a straight pathway from adult services. He added that in the event of specific patient issues outside the patient pathways, then requests for beds would be directed towards him for review and (if appropriate) liaison with forensic services.

16.5 Trust serious incident investigation

The trust investigation was undertaken shortly after the incident on 30 January 2013. It was graded as level 2. The investigation team consisted of:

- consultant psychiatrist and medical lead for eating disorders;
- head of prison health services; and
- patient safety officer.

The terms of reference considered seven areas, including the care and treatment of Mr R, the events leading to the incident, communication between agencies, the trust's adherence to local policy and the quality of service delivery.

The trust investigation team reviewed trust documentation, Mr R's clinical records and local policy. Individual interviews were undertaken with seven members of staff and a focus group was held with 11 members of staff, some of whom were also individually interviewed. Mr R's GP was also interviewed by telephone.

The trust investigation included a comprehensive chronology detailing Mr R's personal history and his care from 1986 up to the incident. The report included Mr R's forensic history, his medication history and his history of risk assessments. Mr R did not wish to be involved in the trust investigation and asked that his family not be approached. At the time of the trust investigation the police had not released details about Mark Austin or his family.

The trust investigation team identified five areas of good practice:

- standard of patient care;
- team working;
- standard of documentation;
- facilitated discharge from hospital; and
- team response to incident.

It did not identify significant care or service delivery problems but four contributory factor/root cause patient factors:

- clinical condition;
- social factors;
- mental/social psychological factors; and
- interpersonal relationships.

On 7 March 2013 the team requested an extension to the deadline for the investigation, which was completed in May 2013. The case was closed on 4 June 2013.

16.6 Analysis

The trust undertook a comprehensive investigation that was underpinned by clear RCA. The investigation report includes a detailed chronology of events, relevant benchmarks, analysis of key issues, clear findings and recommendations.

We felt that there were some areas that could have been explored further by the internal investigation panel and discussed this with the internal investigation lead. We outline these areas below.

16.6.1 Diagnosis

We asked the internal investigation lead whether she had explored Mr R's diagnosis. She told us that she was not in a position to query Mr R's diagnosis because she did not meet him and therefore used the previous diagnosis that had been made.

She added that she did explore Mr R's diagnosis with the team and Dr1. She was of the impression that although Mr R had a diagnosis she felt he was seen by the team in terms of a formulation – a diagnosis didn't capture the complexity of his presentation. The investigation considered whether Mr R had a personality disorder as a secondary diagnosis. The view of the team was that he did not.

16.6.2 Long-term leave

We asked about Mr R's long-term leave and whether the investigation panel explored it with the team. The investigation lead told us that the panel explored the risks in terms of Mr R being on the ward or on leave – there wasn't a "no risk" or "low risk" option available to the team. Mr R was known to get into difficulties with other patients on the ward quite regularly. When Mr R was not engaging with community services there was a lot of outreach work undertaken by the ward (e.g., administering his medication)

16.6.3 CTO

We asked the investigation lead whether she thought a CTO should have been considered at an earlier stage. She told us that it was a matter of judgement, but she did not think it would have made a difference to Mr R. She added that CTOs are at their most effective when patients are respectful of the CTO and that there was no guarantee that Mr R would adhere to the conditions.

16.6.4 Anger management

We asked the investigation lead whether anger management had been explored by the AOT. She told us that there were discussions about this and that the AOT had considered Mr R's anger. She added that it is difficult to compel someone to attend anger management sessions.

16.6.5 Risk assessment and forensic history

We asked the investigation lead if the panel had considered Mr R's risk assessment. She told us that the panel explored Mr R's risk assessment and commented that there wasn't a "no risk option" in relation to managing Mr R on the ward or in the community. She said that the panel had considered whether the team had underestimated the risk Mr R posed and concluded that it hadn't, with the possible exception of one individual, although she added:

> "I don't think that it [the individual's relationship with Mr R] had affected the care plan in terms of the risk level that he [Mr R] was perceived to be…"

We discussed Mr R's forensic history and asked the investigation lead whether the team should have referred Mr R for a forensic assessment. She told us:

> "We did discuss whether it [a forensic assessment] would have been useful… he will not [have been] of a level which would mean forensic services would have taken him on… it is always useful as a second opinion… but I don't think they [the AOT] did because they knew the direction of travel. They were looking at the medication, they were moving towards the CTO, so they didn't feel they had completely run out of the road with him.
>
> "Although the outbursts of aggression occurred over decades, he didn't have the history of really serious offences that would mark him out compared with somebody in a forensic unit, or the sorts of people who are seen by the forensic services as community patients."

We believe that the internal investigation should have given more consideration to Mr R's propensity towards violence, particularly, his forensic history and the implications it had on his risk.

16.6.6 Internal investigation process

We were told by the investigation lead that the interview transcripts were not of the standard she expected and they were not a comprehensive record of the interviews conducted. She told us that it was not possible to cross-reference transcripts.

The trust internal investigation lead also told us that she had concerns about other aspects of the investigation process. These were:

- the investigation timeframe (the geography of the trust meant that it was not possible to complete the investigation by the original deadline, owing to travel and difficulties arranging interviews);
- logistics and arrangements (staff had not been properly briefed, and arrangements had to be followed-up/chased); and
- documentation (e.g. templates).

She told us that she communicated these concerns in writing to the medical director and nursing director. She did not receive any feedback.

We have reviewed the interview transcripts and agree that they were not of an acceptable standard. Although the interview transcripts capture some of what was discussed, we have no assurance that they are a comprehensive record of what was covered. It is possible that certain topics were discussed but not recorded in the interview notes.

Despite this we are confident that the trust internal investigation panel did consider areas that we have outlined above and that there were no significant gaps in the internal investigation apart from the lack of attention given to Mr R's forensic history and its implications to his risk.

16.6.7 Involvement of service user and family

The terms of reference for the internal investigation included:

> "Where appropriate to include contact with friends and family and any information received by them, which may have informed the trust about care, treatment and support offered."

The trust internal report said:

> "[Mr R] does not want details of his care discussed with his family, but they have been offered support in their role as carers."

We met with Mr R's family who told us that they had had no contact with the trust about the internal investigation but that members of the AOT had offered them support shortly after the incident. They added that they had previously engaged with some members of trust staff during the course of Mr R's treatment.

We met with Mark Austin's family. They told us that the trust had not made any contact with them.

The trust internal investigation lead told us that it would have been helpful to have had clarity about the role of the investigation team in relation to engaging with the perpetrator, his family and Mark's family. She felt it would be beneficial to have an additional role within internal investigation that focused solely on family liaison.

It can be difficult to find the balance when working with the family of the victim or that of the perpetrator. In the event of a patient safety incident, the NPSA "*Being open guidance: communicating patient safety incidents with patients, their families and carers*[1]" (2009) highlights the importance of communicating with both the patient and their relatives and/or carers.

We note that when we met Mr R's parents they felt largely unsupported by the trust with the exception of efforts by the AOT to engage shortly after the incident. It is unclear to us whether this was an example of the AOT working proactively or if the practice was policy. We note that the Trust had no contact with Mark's family. Initially this was because of criminal proceedings against Mr R however once he had been convicted the Trust could have made efforts to contact Mark's family. With this in mind we would encourage the trust to clarify its role in relation to supporting relatives after an incident such as that on 30 January 2013.

AOT staff told us that there had been more contact with Mr R's family since the incident with a view to providing support, particularly to his mother.

Details of Mark's family were not available to the trust internal investigation team.

The internal investigation team did not have specific details of the index offence or Mr R's mental state at the time. The team commented on Mr R's history of being violent or misguidedly trying to intervene with/help others, which could lead to instances of violence. The team went on to say:

> "It is possible that the risks of Mr A [Mr R] being violent to another, which were always present, had not increased, and the extent of his actual violence had not increased, but the consequences were far worse than they had ever been before, because of the physical vulnerability of the victim [Mark Austin]."

Our clinical advisor commented:

> "I am concerned that this speculation by the internal inquiry team was inadvisable, especially given the very limited information they had about the index offence, and it would have been far better to have left others, who had that information available to them, to give an opinion about these matters."

[1] http://www.nrls.npsa.nhs.uk/resources/collections/being-open/?entryid45=83726

16.6.8 Finding

The trust internal investigation was comprehensive and underpinned by RCA. It addressed the terms of reference and set clear recommendations in relation to areas of concern.

16.7 Progress against recommendations

The trust internal investigation team made four recommendations:

> 1a) trust review of service models and care pathways to incorporate a review of overall bed capacity;
>
> 1b) trust review of service models and care pathways to ensure that the pathway for admission of assertive outreach patients is clear;
>
> 2) assertive outreach to be represented on electronic patient record clinical and managerial reference group; and
>
> 3) extra supervision for one team member.

The trust drafted an action plan dated 17 May 2013 in the investigation report. Within the plan target dates were set against which the recommendations were to be implemented.

The trust provided us with an updated version of the action plan detailing progress against the recommendations. We interviewed the clinical director for adult mental health services to explore this further. He explained that as of March 2014 the service has been restructured into three directorates:

- children's services (including all child and adolescent mental health services, eating disorders, some non-mental health community services and learning disabilities);
- adults; and
- community (all community non-mental health services and older people's mental health).

The aim of the restructure was to create clear care pathways for patients and clear links with partner organisations and commissioners.

He explained that the AOT, as it was, does not exist in the new service model. In terms of adult services, there is now a seven-days-a-week service, 7am to 9pm, and services (e.g., CMHT, early intervention, home treatment, crisis, etc.) have been aligned under locality headings which link to the commissioning localities. They are operating multidisciplinary teams that include social workers. The exception to this is psychological services, which remain a separate pathway.

Across Oxfordshire and Buckinghamshire the trust now has five adult mental health teams which serve the local population. The teams no longer have discrete services, as the AOT did, but rather have an assessment function and a treatment function.

16.8 1a)Trust review of service models and care pathways to incorporate a review of overall bed capacity

The trust action plan recorded this as completed on 4 June 2013 against a target of 1 November 2013. The action plan reports that the division was remodelled in 2013 and that dedicated consultants became available in May in Buckinghamshire and in November in Oxfordshire. In addition, each ward has a modern matron post and ward-based staffing was increased from March 2013. There are daily reviews of inpatient capacity. In addition there has been a review of the community services offering seven days-a-week services, leading to a locality team model.

The action plan states that patients on section 17 leave can be recalled to hospital if required and that (as of June 2013) patients recalled were admitted within 24 hours. The trust mental health act office has started to keep data on patients on section 17 leave who are recalled. The action plan recorded that as of June 2013 there had been nine recalls of patients on CTOs in the previous three months, and two recalls of patients on section 17 leave.

The clinical director for adult mental health services confirmed the details above and told us that over the last five years there has been a project to re-provide inpatient care in Buckinghamshire. In February 2014 the trust opened the Whiteleaf and Wellbeing Campus, which includes community bases for teams and has four inpatient wards (male and female acute adult, older adults and rehabilitation). Each ward has 20 beds and is en-suite. In Buckinghamshire there has been a reduction in total bed stock (44 acute to 40 male and female beds).

The clinical director added that some of the Oxfordshire facilities are not what they would wish for to deliver services, but some buildings are listed, which creates further difficulties. There is a 13-bed intensive care unit which serves both counties. There are four wards across the Oxfordshire site, two of which have been upgraded to meet privacy and dignity standards and improve access to 136 suites. This has led to a slight reduction in bed stock.

16.8.1 Comment

We note that changes to the service structure have only recently been implemented, including the opening of the Whiteleaf and Wellbeing Campus. As a result it is not possible to comment on the effectiveness of these changes.

The trust monitors bed capacity and section 17 leave. We were told that this information is recorded centrally and that the clinical director is able to access it. We saw an example of this type of report.

The clinical director told us that there had not been any instances of the trust being unable to provide a bed for a recalled patient. He added that it is a challenge for the trust to manage capacity against section 17 leave. Out of office hours there are duty consultants and duty managers who will look at capacity. The trust is working to a day time duty consultant for the inpatient service creating a single channel for requests to be directed. The trust does not have a dedicated bed manager for acute services, partly because bed managers do not have the authority to admit or discharge, and partly because a post such as this can often absolve managers and clinicians from managing bed demand and supply.

We were shown an example of the report (similar to a dashboard) that the on-call consultant and on-call head of service will receive at handover from the on-call manager. This information includes capacity on the wards, anticipated inflow/outflow, staffing levels and any issues on a ward (e.g., levels of observation). The information is available daily as part of the handover.

We were told that senior clinical team members can access the dashboard, which provides staff with an overview of data around the wards. They are able to drill down and conduct trend analysis of the information (e.g., the total number of patients on extended section leave 17 above or below 30 days).

16.8.2 Analysis

The dashboard appeared to be an effective system by which to monitor bed capacity, although we agree with the clinical director's point that it is reliant on the correct information being routinely provided by staff.

We recognise that the new service model is very much in its infancy, having been implemented only in March 2014.

16.9 1b) Trust review of service models and care pathways to ensure that the pathway for admission of assertive outreach patients is clear

The trust action plan recorded this recommendation as met on 15 August 2013. It cites the remodelled locality teams covering assessment and treatment as the single pathway for patients from community to inpatient. Consultants are responsible for admission, discharge and bed allocation. The new pathway model has been approved by the executive team.

The action plan recorded that on all wards in Buckinghamshire and Oxfordshire there had been 997 adult inpatient admissions and 1,027 discharges between the end of

February and early August. Of these, there are had been 14 ECRs[1] by early August, ranging from one to 14 days, in the previous three months (preceding August 2013).

16.9.1 Comment:

> We have previously outlined the recent changes to the service structure and the implications for the patient pathway. These changes remain in their infancy and it is not possible to evaluate or assess their effectiveness.

We were impressed with the former AOT when we interviewed the group. The former team members acted in a cohesive and collaborative manner and showed dedication and insight. We hope that the trust has taken steps to ensure that this ethos endures in the service restructure.

16.10 2) Assertive outreach to be represented on electronic patient record clinical and managerial reference group

The action plan records this recommendation as achieved on 15 August 2013. It reports that the AOT deputy manager (band 7) represents the division on the electronic health record (EHR). The City team manager represents the locality teams on the EHR reference group. Both individuals are members of the clinical and managerial reference group for the procurement of the RiO[2] electronic patient record replacement.

Two members of what was the AOT confirmed that they had attended a meeting about the electronic patient record, although they added that they had to proactively seek the details of the meeting in order to attend (they did not receive invitations). At this meeting they were presented with options to choose from rather than consulted. They did not receive any more information after the meeting.

16.11 3) Support one team member with extra supervision regarding risk and assessment and management and therapeutic boundaries

The action plan records this as achieved on 29 May 2013. The lead nurse for community (Bucks) offered clinical supervision to this individual to address concerns identified by the internal investigation.

Dr1 confirmed that this member of staff had received additional supervision. She added that the person in question had not been closely involved in Mr R's care.

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[1] When a patient is referred to a service for which there is not a standing contract, this is termed an extra contractual referral (ECR)

[2] RiO is the electronic patient management system historically used by the trust that is now being replaced.

16.12 Recommendation

We recommend that the trust review the effectiveness of the new service model in 12 to 18 months. The trust should reflect on the recommendations of the trust internal investigation to ensure that progress of their implementation continues to be made within the new service model. Particular attention should be given to the patient pathway and implementation of the new electronic patient record.

17. Overall Analysis

Mr R had an extensive mental health history dating back 30 years. He had a forensic history that included disorderly conduct, robbery and actual bodily harm. Mr R was well known to the AOT, which at times found him intimidating and aggressive. Despite this he was well liked by the team and was known as quite a character who could be engaging and pleasant.

Mr R's diagnosis of a bipolar affective disorder was reasonable, although we feel that Mr R met the criteria for the diagnosis of an antisocial personality disorder. We are of the opinion that there were indicators for this but that the AOT attributed these to his personality as opposed to his diagnosis. Had this been explored further it is possible that different treatment options would have been considered. Dr1 told us that she felt the AOT attributed much of his behaviour to his diagnosis of a bipolar disorder.

Mr R's risk was explored by the AOT, which undertook extensive steps to manage it. Despite this we consider that the team could at times underestimate Mr R's risk, particularly in relation to potentially having an antisocial personality disorder. From this we believe that there would have been benefit in referring Mr R to forensic services with a view to considering his diagnosis and risk. While we acknowledge that he was unlikely to have been accepted by the service at that time, it may have been helpful to seek advice in relation to managing Mr R.

Mr R was well known to the AOT, which could be both a benefit and a hindrance to the team. We note the efforts undertaken by the team to engage and work with Mr R, particularly as at times he would not engage. It is at these times that some distance from Mr R might have provided the team with further insight into alternative means of managing him, be it via the MHA or the criminal justice system.

In the latter stages of 2012 the team was taking steps towards implementing a CTO which we were advised had taken some time to arrange. Although the CTO would be reliant on Mr R's compliance, he had previously adhered to the conditions of a community probation order when the AOT described him as easiest to manage. With this in mind a CTO was an appropriate course of action for the AOT to take. This was scheduled to be implemented on 4 February 2013 – five days after the incident occurred on 30 January 2013.

We have considered the evidence and information available to the AOT in early 2013 and have concluded that there were no means by which the team could have predicted or prevented the incident. Mr R had not voiced any intention to harm others; neither had he displayed unusual or destructive behaviour. There had been an instance of Mr R being threatening, but this not out of keeping with his presentation. He was known to be "predictably unpredictable". Although it could reasonably be predicted that Mr R would be violent/aggressive – particularly when taking account of his history – there was no means by which the team could foresee when this violence might recur, or its extent.

During January 2013 Mr R's mental state was more settled and there were no grounds for the team to recall Mr R to the ward or use the MHA to detain Mr R and therefore no opportunity for it to prevent the event on 30 January 2013.

18. Statement from the victim's family

Mark Austin's family were invited to write about their thoughts and feelings in relation the findings of this report. The independent investigation team has taken the decision to include in full the family's thoughts. Whilst the independent investigation team might not have found the evidence to support everything written by the family, and at times express different interpretations in the main body of the report, we are of the view that it is essential the family have the opportunity to express their thoughts and feelings in full. We respect the reflections offered by the family and want to ensure that we provide an opportunity for them to be shared.

18.1 Family statement on Mark Austin - Mr R Verita independent investigation

I MARK

Mark Austin was a very much loved father, son, husband, brother and grandfather and was also a talented musician. He had a daughter, 5 grandsons and a granddaughter who, along with the rest of his family will miss him for the rest of their lives. His mother's life will never be the same again since the day that she was told that the injuries Mark had sustained from Mr R's brutal blows were so bad that he would not survive, even after the 36 hours doctors at Stoke Mandeville Hospital spent trying to save his life. That same day the doctors disconnected Marks' life support. His mum lay her head on his chest and cuddled him tightly as his heart beats slowed and finally stopped.

It's always extremely sad when a loved one dies and our hearts are with all who are bereft especially those who have lost family/friends in such cruel circumstances and to the hands of someone that clearly should have been detained in a psychiatric facility as Mr R should have been. It is very difficult to go on knowing that the last thing that our beloved Mark heard, saw or felt was Mr R punching the life out of him and is certainly something that we will never forget or stop thinking about.

II THE REPORT

We knew from the trial that Mr R had a long history of mental illness and violent offending but were shocked, by the Verita report, at the extent of his aggression and abusive behavior - including indecent exposure, serious assaults on staff, violence towards women and even threats to kill.

Mr R had previously been detained under the mental health act as a danger to the public, but was released after just four months.

It was known by NHS staff that Mr R would often avoid taking the medication he needed to keep him mentally stable.

We learned too that Mr R's clinical records did not reflect the true extent of his history of physical violence, and that clinical staff all too often excused, or made allowances for his anti-social and violent behaviour, we feel that the clinical staff responsible for Mr R became too familiar with him which made the staff somewhat complacent.

Just two months before he killed Mark, Mr R was considered, by medical staff extremely, mentally unwell and determined that he should be treated in hospital, however, as no bed was available it was decided that they would treat him at home (in the community) regardless of his record of aggression and violence.

Two weeks before killing Mark Austin Mr R was distressed and asking to be admitted to hospital, again due to lack of NHS resources it was decided that he should be treated at his home in Aylesbury, Bucks. Mr R and the doctors knew from past episodes that Mr R was a danger to others and could not be trusted which makes one question why he was not detained, regardless of the lack of beds.

Just a week before the incident Mr R was threatening and aggressive towards clinical staff who had arrived at his house to medicate him but due to his behavior they were frightened and unable to administer his medication and terminated the meeting. This should have raised an alarm! But nothing was done. Mr R was off his medication and clearly deteriorating, yet it seems to us, from the evidence in the report, that no effective or urgent action was taken.

We disagree profoundly with the report's conclusion that Mark's death was neither predictable nor preventable.

We believe Mark's killing may well have been prevented had full and accurate clinical records been kept, had risk assessments been fully documented to include Mr R's previous offending history, and had the treating team not made unwarranted allowances for his repeated violence and anti-social behaviour.

III FAMILY INVOLVEMENT

We were disappointed not to have been kept sufficiently informed during the conduct of this investigation

In fact, we have found that with this whole process there has been a constant lack of communication and we have had to scrape around for information. Why is this not made easier for the affected families? Haven't we already been through enough?

IV EFFECTIVE CHANGE

We are aware that there are many reports of this kind after killings by mentally ill patients, but there is little evidence of real and effective changes in practice of care as a result.

Mr R is not, as we believe he should be, incarcerated in a prison, he is in a four-star mental health facility, affording him benefits, from television and games, fully equipped gym and tea and coffee on tap.

From the evidence in the report it seems Mr R has become very good at manipulating NHS medical staff into believing he can control his behavior and is not as ill as he really is. We believe this history of manipulative and self-serving behaviour has enabled him to gain day release with the possibility of an earlier release date back into the community (he may already have been released, we have not been able to get this information). Based on Mr R's documented history, allowing him back into the community at such an early stage of his rehabilitation will we believe undoubtedly result in him, once again, falling into his 30 or so year lifestyle of alcohol and drug abuse, failure to take his medication and could possibly result in this horrid event repeating itself in the future. Is it not a contradiction to say: Mr R is too mentally unstable to be responsible for killing Mark and be punished for what he has done, but is well enough to be free in the community? One or the other, please! How many people have to die or be injured and maimed before "LESSONS ARE actually LEARNED" ...

We do not want any other family to suffer as we have done. Unfortunately, it is too late to do anything for our beloved Mark, but we want his legacy, and the outcome of this report to be real and to make a difference and encourage changes in the mental health services which will hopefully prevent future, AVOIDABLE tragedies like this one from ever occurring again.

Mark Austin's Family
August 2017

Appendix A

Biographies

Kathryn Hyde-Bales

Kathryn is a senior consultant at Verita with a background in investigations and regulation. She previously worked at the Care Quality Commission (CQC) where she managed the provision of analytical support to standalone projects and regional teams covering the NHS, independent and social care sectors. At Verita she has worked on numerous mental health homicides, reviews of safety at homes providing care for the elderly and on clearing a backlog of complaints at a Midlands trust. Kathryn was a member of the team providing oversight of the three main NHS investigations into allegations about sexual abuse by Jimmy Savile.

Andy Nash

Andy has a background in management in local government and the NHS and started his career as a social worker. He has also worked in national inspection and regulation, service improvement and policy development and implementation at the Department of Health. His specialist fields are social care and mental health. Andy now works as an independent consultant.

Dr Martin Lock

Dr Lock is a consultant forensic psychiatrist in private practice with extensive experience in adult general and forensic psychiatry. He has worked in all levels of secure psychiatric care, in HMP Wormwood Scrubs, run a court diversion scheme and worked in a drug dependency clinic, an alcohol clinic and a mother and baby unit.

Since joining the Mental Health Review Tribunal as a medical member in 2003, Dr Lock has sat on almost a thousand tribunals. In addition to this he sat on hundreds of cases during his time on the Parole Board of England and Wales.

Tariq Hussain

Tariq is a former nurse director who brings to Verita his considerable experience in the fields of learning disability and mental health services. Tariq has undertaken a wide range of reviews for Verita, including numerous mental health homicide investigations.

Before joining Verita he served for eight years as a non-executive director of a mental health trust with board level responsibility for complaints and serious untoward incident investigations. Tariq also gained extensive experience of investigations and tribunals as director of professional conduct at the UK Central Council for Nursing, Midwifery and Health Visiting. He has also served as a member of the disciplinary committee of the Royal Pharmaceutical Society of Great Britain.

Appendix B

Documents reviewed

Medical records

- Mr R's medical and nursing records

Policies and procedures

- *Care Programme Approach policy (including non CPA)*
- *Clinical Risk Assessment and Management policy*
- *Discharge policy*
- *Non Attendance for Appointments policy*
- *Mental Health Act (MHA) policy*
- *Policy and Procedure for Reporting and Management of Incidents, including Serious Incidents Requiring Investigation (SIRI)*
- *Clinical Model for Inpatient Care, mental health division*

Internal report

- Initial investigation report
- SUI review report, May 2013
- SUI interview transcripts
- Action plan

Other

- MAPPA information
- *The investigation of serious patient safety incidents in mental health services* (2008). NPSA.
- *Being open guidance: communicating patient safety incidents with patients, their families and carers* (2009). NPSA.
- *Correspondence between health care professionals*