Independent review into treatment and care provided by 2Gether NHS Mental Health Foundation Trust

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EXECUTIVE SUMMARY

INVESTIGATION INTO CARE AND TREATMENT PROVIDED BY 2GETHER MENTAL HEALTH NHS FOUNDATION TRUST

1. Introduction

1.1. This is the report of an investigation commissioned by NHS England into care and treatment provided by 2Gether NHS Mental Health Foundation Trust for `X' who was an inpatient at the Montpellier Low Secure Unit when he killed SW, a Health Care Assistant, on 9th July 2014. We would like to extend our sincere condolences to the victim's family for the tragic loss of someone much loved.

1.2. Details about how the investigation was commissioned; its Terms of Reference; the team, and the methodology we used can be found in the main report attached. We would like to thank the 27 staff and the other organizations who agreed to participate in the investigation process. The team is also grateful to the Trust for assisting us to access policy documents, case notes and other material relevant to the care that was provided for X in 2014 and understand how services are provided now.

2. Background

2.1. A full chronology of the care and treatment provided for X may be found in the main report (Appendix 6). X was first transferred to Montpellier in June 2012 at the age of sixty. Almost thirty years before, in 1983 at age 31 he had been found guilty on two counts of murder and robbery and had been sentenced to life imprisonment with a minimum duration of 25 years. However, whilst in prison his mental health deteriorated, and he was transferred Broadmoor High Secure Hospital (in 1991). Over the years that followed he was moved to medium and then low secure units (latterly the Montpellier Unit in 2012). His diagnosis was given as paranoid schizophrenia.

2.2. During this time, X had only one acute relapse of his psychotic symptoms and he was physically violent on only one occasion: in 2010 he smashed a television set in the lounge after falling out with hospital staff after they (mistakenly) accused him of breaching the boundaries of his leave. However, he was also described as lacking insight into his mental illness; he often questioned the value of taking medication and was generally suspicious and mistrustful.

2.3. X transferred to Montpellier Low Secure Unit in June 2012 on Section 47/49 of the Mental Health ACT (MHA). His care included a range of treatment and activities, including psychological therapy, anti-psychotic medication and treatment for his physical health risks. There were also a few occasions when X's challenging behavior or interpersonal tensions led to conflict with staff or other patients. However, on the whole, X's behavior and mental health remained stable. The notes record that his diagnosis was elaborated after the first year to include Anti-social/Dissocial Personality Disorder.

2.4. After three months at Montpellier (in September 2012), consideration was given to moving X to unit for ex-offenders that had a more rehabilitative focus. After initially expressing interest in moving, X subsequently decided he didn't want to go. Consideration was then given in 2014 to another Unit in Wales which X visited and initially seemed to like. However, he subsequently expressed a reluctance to move. When the decision was taken by the clinical team that it was nonetheless the most appropriate placement for him, X made veiled threats heard by some staff that he would not be unpacking his bag; he said he would sooner return to prison than go there.

3. The incident

3.1. On the morning of 9th July 2014, X stabbed and killed a Healthcare Assistant. Further detail about the events of this day and the management of the incident can be found in the main report. Our team reviewed the way that the staff team managed the events of that day; we found no reason to believe that they did not behave in a wholly appropriate and professional manner.

4. Findings and conclusions

4.1. Overall, our team found no evidence to believe that the mental and physical health care and treatment provided at Montpellier for X was not provided to a good standard. In 2014, individualized care plans were written in consultation with the patient based on the `My Shared Pathway' model. X had such a plan; it was fully appropriate in view of his history and the intention to support his rehabilitation through to lower levels of security and, ultimately, his discharge from his Mental Health Act Section and detention. He had a `Pathway Coordinator'; there was an identified clinical lead in place, and risk assessments linked to the Care Plan were in place.

4.2. It is possible that X was more mentally unwell than he appeared prior to the decision that he should move to Wales. However, the psychiatric assessment that was completed immediately after the incident that resulted in the sad death of Ms W did not reveal any signs of psychotic illness. There was no evidence to suggest that staff missed anything significant in their assessment of X and the risk he presented. Overall, our team were impressed with the quality of the care provided, and with the quality of the highly motivated well-led clinical team.

4.3. Twenty recommendations to strengthen services were nonetheless made after a comprehensive internal investigation. These can be found in the main report at Appendix 2. The Health and Safety Executive (HSE) who conducted their own investigation, completed in 2016 also identified areas as needing improvement (risk assessment, lone working and search policy and procedure). Our team is also able to confirm that all these recommendations have been met.

4.4. The team at Montpellier have thoroughly overhauled their policy in all areas relating to risk. For example, in the summer of 2015, the Director of Quality set up a 'positive and safe' subcommittee, reporting to non-executive directors through the governance committee, chaired by the assistant director of governance and compliance. Staff training in risk assessment and management was strengthened and the Unit now screens all patients using a structured assessment tool (HCR20) as well as the Structured Assessment of Protective Factors for Violence Risk (SAPROF).

4.5. Several other changes have also been made since 2014. For example, notes of discussions at multi-disciplinary meetings are now recorded contemporaneously in the patients' notes rather than afterwards. A plan of training in the management of patients with Personality Disorder has been implemented. Search policies, lone worker policy, observation policy, and policy on the use of restraint have been revised. New equipment used to search patients and visitors has been installed, and CCTV and systems to support patients' restricted access to the internet have been overhauled.

4.6. Our team believes that the decision to move X to Wales was broadly appropriate. It is also clear that X was involved in an appropriate way in the decision, which was discussed fully with him even though he was given little notice of the date of the move. Transfer checklists have now been designed to promote a more structured approach to the follow-up and implementation of decisions to admit and/or transfer patients to ensure that this is better managed in future.

4.7. After the incident which resulted in the tragic death of Ms W, X was transferred to prison. Eighteen months later in 2016, he began once again to show signs of psychotic illness and he was transferred once again to Broadmoor High Secure Hospital where he currently remains.

4.8. Together with evidence gathered during our investigation about the quality of care that was provided for X, our team does not believe that the incident which resulted in the tragic death of Ms W could have been predicted or prevented. The Trust took all reasonable steps to avoid a violent incident. Appropriate policies and systems were in place; a risk assessment had been completed and, although it is unlikely that a short notice given for X's move strengthened his personal motivation to go, it potentially made the move easier for staff to manage.

4.9. Neither the internal report, nor the Health and Safety executive (HSE) thought that the shortcomings they identified were causative or linked to the tragic death of Ms W and the HSE concluded that there was no basis for taking legal action beyond the Notice of Contravention (NoC) issued in March 2015. Our conclusions mirror these.

5. Recommendations

5.1. Our team has three recommendations to make. The first concerns the importance of ensuring that staff at Montpellier have the opportunity to see this report and discuss, if they wish, any points arising from it. We will arrange an opportunity to do this.

5.2. The second concerns what we believe to be a need to review the structure of the staffing arrangements to ensure that an appropriate balance of trained and untrained, senior and junior staff is available to deliver the best quality of safe care in what we judge to be a challenging environment.

5.3. The third recommendation concerns the importance of maintaining awareness of risk, and of action to reduce the risk that staff are so affected by the process of investigation(s) that their mental health, commitment and quality of service delivery are potentially affected. More detail may be found in the main report.

REPORT OF AN INDEPENDENT INVESTIGATION INTO CARE AND TREATMENT PROVIDED FOR `M' BY 2GETHER MENTAL HEALTH NHS FOUNDATION TRUST

1. Introduction

1.1. This is the report of an investigation commissioned by NHS England into care and treatment provided by 2Gether NHS Mental Health Foundation Trust (`the Trust') for `X' who was in receipt of care by the Trust when he killed Ms W, a Health Care Assistant, on 9th July 2014 at the Montpellier Low Secure Unit. Ms. W. was fulfilling her early morning observation duties when she was stabbed twice in the back with a kitchen knife that X had obtained and concealed.

1.2. We would like to extend our sincere condolences to Ms W's family for their tragic loss. We hope that our report will help them to understand the background to the care that X received, and the steps that have been taken to strengthen services. We also hope it will assist all those at the Trust who were involved the case. Our primary aim is to learn lessons from this tragic death, help to improve mental health services and make them safer.

1.3. This investigation, commissioned by NHS England was established under the Department of Health Article 2 of the European Convention on Human Rights, and guidance published by NHS England[1] for investigating serious incidents in mental health services.

1.4. Specific Terms of Reference (TOR) were developed for the work (see Appendix 1). These required a focus on present day services and current processes as well as a look back over the events that led to Ms W's sad death. The TOR specified that investigators should review findings and the recommendations that were made in a very detailed internal report presented to the Trust in January 2015; conclusions drawn following a detailed eighteen-month investigation by the Health and Safety Executive which was completed in 2016, as well as actions taken by the Trust to review safety and strengthen services.

1.5. Appendix 3 contains details about the investigation team appointed by NHS England. The team includes individuals with a wide range of relevant skills and training including

[1] NHS England Patient Safety Domain (2015) `Revised Serious Incident Framework: Supporting learning to prevent recurrence.' www.england.nhs.uk/patientsafety/

Forensic Psychiatry, Social Work, Secure services management, Nursing, Clinical Psychology, Mental health policy development, service management, and teaching.

1.6. Montpellier is a low secure rehabilitation facility for twelve men with a primary diagnosis of serious mental illness. Patients tend to stay for between six months and two years. Care is provided by a multi-disciplinary team including nurses, doctors, a psychologist, occupational and sports therapists and a social worker. It is sited within Wotton Lawn Hospital in Gloucester.

1.7. We would like to thank the staff who agreed to participate in this investigation, and the other organizations (Care Quality Commission, Police, Health and Safety Executive, NHS Improvement) who were involved in reviewing services. We recognize that the investigative process has been lengthy and that it has been very difficult for everyone involved; not only for Ms W's family but the staff who worked closely with Ms W at Montpellier and knew her very well. Many remain very affected by the events of that day.

2. Methodology

2.1. An initial `scoping' meeting was held on 1st September 2017 with the commissioner of the investigation (NHS England), representatives from the Trust and the local commissioning team. Agreement was reached about the methods we would use to examine the facts of the case, identify ways in which care might have been altered or improved, and to understand how systems for delivering care and managing risk are currently working. We also discussed how best to present information to staff about this and previous investigations to which they only had restricted access.

2.2. Appendix 3 contains a list of the 27 individuals with whom the investigation team spoke about the care and treatment provided for X around the time of this tragic incident and/or afterwards. Six of the staff had been present at the time of the incident; the others were new in post over the past three years.

2.3. Owing to the length of time elapsed since the incident and the absence of staff who had been in post at the time, it was agreed that the investigation team should see transcripts of witnesses interviewed for the Stage 2 investigation in order to help validate its content. It was further agreed at the scoping meeting that, owing to the level of pressure on staff over so prolonged a period of investigations, it would be appropriate to see them in small mixed groups rather than individually. Therefore, with the exception of the medical staff,

small groups of equivalently `banded' staff and teams (such as the Governance Team) were seen together.

2.4. Appendix 4 contains a list of all the Trust policies, case notes, records and correspondence reviewed by the team over the course of their investigation. This `desktop review' permitted an appraisal of current policies including care planning, care coordination, searches policy, risk assessment and management and protocols governing the operation of the low secure setting where X was treated. We reviewed the internal report that was prepared by an independent group of Trust clinicians and presented to the Board on 22nd January 2015, six months after the incident occurred. We liaised with the Governance Team with responsibility for oversight of the implementation of actions arising from recommendations made in the internal report and we looked at documentation reports that evidenced this for the Trust Board.

2.5. Our team spoke with a representative from the Health and Safety Executive (HSE) to understand more about the process[2] that they followed when they investigated the Trust over a period of almost two years to October 2016 to understand whether Health and Safety legislation had been breached by the Trust following the tragic death of Ms W[3]. The HSE identified breaches of health and safety law during the investigation and took enforcement action in the form of a Notification of Contravention (NoC) which was served on 25th March 2015.

2.6. The HSE is required to keep employees and their representatives informed on matters which affect their health and safety and a copy of the NoC was shared with UNISON representatives. The breaches of health and safety were also raised directly with the Trust prior to the NoC being served. The HSE does not publish documents or reports in the way that the Care Quality Commission (CQC) does. However, HSE representatives met with the Trust Board in October 2016 to discuss the outcome of their investigation and wrote to the Trust. The Trust Chief Executive then wrote to all staff to inform them. Once remedial steps relating to the breaches had been taken the HSE wrote to the Trust in February 2017 to confirm that no further action would be taken.

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[2] The HSE guide to investigations can be found at: http://www.hse.gov.uk/enforce/enforcementguide/investigation/index.htm

[3] More information about the process followed by the HSE when they investigate work related deaths can be found at: http://www.hse.gov.uk/enforce/enforcementguide/wrdeaths/index.htm

2.7. Lastly, the team was able to view a random sample of electronic case notes containing information about the care planning, risk assessments and communications relating to six other patients currently detained at Montpellier. Together with the staff interviews, these documents evidenced the extent of oversight of and learning and change in practice since 2014 and enabled the team to come to a judgement about whether the Unit is now functioning in a manner consistent with agreed good practice as set out in local and national policies relating to care and the delivery of low secure services. The team would like to thank the Trust staff for their helpful and very candid approach in speaking with us, especially as many remain very distressed about the loss of their friend and colleague.

3. X gave his consent for the investigation team to access his medical records and speak with staff about his history and his care. However, on the advice of the clinicians in Broadmoor, the team did not speak personally with him. Instead, the team did spoke with the forensic psychiatrist with responsibility for X's clinical care with the aim of obtaining an opinion about his diagnosis, treatment, risk, and insight; this is described in a later section. A copy of this report is also being forwarded to X's psychiatrist so that it may be discussed with him if this is judged clinically appropriate. Members of Ms W's family were not, in the event, contacted directly by the investigation team owing to several miscommunications, but they have had the opportunity to review the report and provided some comments which have been incorporated.

4. Background

4.1. A chronology of the events that led up to the sad death of Ms W is provided in Appendix 6. A narrative summary of the facts of the case, X's personal and psychiatric history, the incident and its immediate antecedents and consequences is provided below.

4.2. X was born in 1952 in Gloucestershire, the youngest of three siblings: he has an older brother and an older sister but has no contact with them. From information available in the case notes, we understand that X described an austere childhood with a distant, absent father who died in 1981 when X was 29. X's mother is also now deceased. X left school at 15 and worked as a metal polisher and at 18 he met (D), 2 years younger, whom he married at age 20 in 1972. There was a daughter from this marriage (S) who was born whilst X was in Borstal. The marriage ended after a year and X is no longer in contact with his daughter. In 1980 at the age of 28, X moved to Devon and met (W) who had a daughter (P); this relationship then also broke down and X was arrested for a violent incident at the home of his parents-in-law.

4.3. X has a history of contact with the criminal justice system dating back to when he was 12 or 13 when he was referred to Child Guidance. Police records apparently show a succession of offences including indecent assault, possession of an offensive weapon, malicious wounding, threatening behavior, and criminal damage. In 1982, X was involved in a silver bullion robbery with two co-offenders. One (B) was subsequently arrested but released. Fearing that they were at risk of him informing on them, X and his co-offender killed B. Shortly afterwards, they also killed B's 16yr old daughter because she knew their names. Sentencing the two offenders to life imprisonment, the judge described the murders as `utterly callous and cold-blooded'.

4.4. It was five or six years later whilst he was in prison in HMP Cordingly in 1989 that X showed the first indications that he had a formal mental illness as well as adjustment and behaviour problems. He became depressed and isolated and was transferred in 1990 to HMP Maidstone. The following year in January 1991 he was segregated from other prisoners due to concerns about his mental state: he was agitated; believed he would be killed by another inmate whose daughter he (apparently delusionally) believed he might have raped, and he reported believing that the devil would visit to kill him in the night. He was placed on suicide watch. In 1991, X was transferred to Broadmoor High Secure Hospital with more florid symptoms of a paranoid, depressive and psychotic state. As threats had been made at the time of X's trial by B's family that they would take revenge on him, it is possible that this provided a foundation for his fears.

4.5. In 1996, X was returned to HMP Parkhurst after being treated with anti-psychotic and anti-depressant medication whilst in Broadmoor Hospital, but he relapsed three years later and in 1999 he was transferred back to Broadmoor Hospital. He was described as having: `paranoid personality disorder with an entrenched delusional system and episodes of paranoid psychosis characterized by passivity phenomena, auditory and visual hallucinations, and delusions of a grandiose and persecutory nature.' The treating psychiatrist considered that X `lacked insight into the nature of his mental ill ness and the need for medical treatment.' It was noted that during acute relapses, X was difficult to manage and barricaded himself in his room. He continued to have intermittent episodes of depression, anxiety and psychosis generally associated with a reduction of (or a failure to take) medication.

4.6. By the end of 2003, X was consenting to take anti-psychotic medication on a regular basis and was well enough to consider stepping down to medium security. The Home Office agreed to a trial period of leave and in 2004, X was given a placement at Chadwick Lodge,

a Medium Secure Unit (part of the Priory Group) providing specialist treatment for patients who have been detained under the Mental Health Act who have a history of offending. The following year (2005) X moved full time into Chadwick Lodge where he remained for 7 years. Initially, he received psychological treatment focused on identifying early warning signs of a mental ill health relapse. However, his `talking treatment' ended after 12 weeks because X apparently found it too anxiety-provoking. Risk assessments completed around this time emphasize the difficulty that X experienced expressing and managing his emotions (especially anger), mistrust of women, and his social isolation.

4.7. X suffered one relapse in 2007 when he was moved into more secure detention (also at Chadwick Lodge): he thought other inmates and people in the community (when out on visits) were trying to kill him. At this time, X also neglected his personal hygiene and gave a report of attempting suicide. Then, in 2010, he fell out with hospital staff after being falsely accused (it was a case of mistaken identity) of breaching the boundaries of his leave; he smashed a television set and was moved back again into medium secure detention (although he said that the move was his own choice). By the time he was considered suitable to be moved to Montpellier, X seemed very keen to go and he had disengaged with staff.

4.8. During the first phase of X's assessment by the Montpellier team, restrictions that were normal for a new patient being assessed were imposed and X was initially allowed only 30 minutes of leave. There were 10 other patients on the Unit at the time and staffing levels were good. The summary of risk available in the notes is thorough and describes X's continuing lack of insight, his continuing mistrust of and lack of respect for women, and his relative social isolation. The risk assessment emphasized X's lack of insight and the importance of maintaining his medication: an anti-psychotic (Quetiapine 300mg) that the psychiatrist described as a `middling dose' which X self-administered only reluctantly because of the side effects.

4.9. The course of X's stay at Montpellier was characterized by a gradual extension of his privileges (such as leave); his mental health and behavior remained broadly stable and he began to engage with psychological therapy. However, the notes record a falling-out with an Occupational Therapy Technician (OTT) about whom X made an unsubstantiated complaint, and M's dislike of the OTT was maintained over several weeks. This was dealt with appropriately in that the matter was investigated, and the OTT supported in dealings with X. After three months at Montpellier, (September 2012), consideration was given to moving X to Knole in Cheltenham, a rehabilitation unit for ex-offenders. After initially expressing interest, X decided he didn't want to go there because the unit allowed only

very restricted access to the internet; it was `full of paedophiles' (sic) and residents were expected to stay for at least a year. In November, the Parole Board refused X's request to be released and this frustrated and annoyed him.

4.10. X stayed at Montpellier but, during the following year (2013), there were several incidents that suggested either that the placement was beginning to break down or that perhaps he was starting to become unwell. For example, altercations continued with the OTT (investigations were conducted but X's complaints were not upheld); X breached his agreement regarding use of the internet; he breached his leave arrangements; leave was suspended for a time, and `items of concern' were found in his room. X isolated himself and continued to complain that his medication was causing adverse side-effects. The notes record X as attempting to `split' professional opinion and his diagnosis (paranoid schizophrenia) was elaborated to include a diagnosis of Anti-social/Dissocial Personality Disorder. X also began to report fears that another patient was trying to kill him. However, on this occasion it was true that he had been threatened.

4.11. By the middle of 2014, X was asking to be transferred from Montpellier and discussions began regarding a placement at Ty Catrin near Cardiff, a low-secure unit offering recovery-oriented specialist treatment for people with mental illness and Personality Disorder. X made a visit to Ty Catrin on 5th June which appeared to go well although once again he said he didn't like their policy regarding access to the internet or the fact that inpatients were expected to stay for at least a year.

4.12. Arrangements were progressed at the Multi-disciplinary Team meeting on 29th June to move X to Ty Catrin and on 1st July at a meeting with the Unit Manager, X reported that his relationship with professionals in Montpellier had `broken down'. On 2nd July, at a professionals' meeting, the notes record a discussion of how the transfer to Ty Catrin should be managed and communicated. According to the internal report, opinion on this point was apparently divided between staff: some were unclear about how and when X would be told the date; others thought he knew. The notes record the decision to give X 24 hours' notice of a move on Wednesday July 9th. Risks were considered, including the risk that he would protest about the move. However, as X's more dangerous behaviour such as making weapons or barricading himself in his room had, in the past, been associated with a significant deterioration in his mental state, professionals judged the risk of harm to X himself or to others to be low. Whilst X's advocate argued that alternative placements should be considered, the team agreed that Ty Catrin was the most appropriate place for him.

4.13. By 4h July, X had packed a bag ready to leave but he apparently told a HCA that he wouldn't be unpacking it. She quoted him as saying: `By hook or by crook, I'm going back to prison' He made other veiled threats saying: `I know what I'm capable of', and there were grumbling disagreements that day between X and other patients. On the 8th July, there was a further altercation with the OTT who had taken the Unit car to pick patients up from town. X complained that the car had been moved before he had fastened his seat-belt and he got out of the car and walked back in breach of the rules. However, that night passed uneventfully.

5. The incident

5.1. On the morning of Wednesday 9th July 2014, at approximately 0725hrs, Ms W left the office to complete her morning check of patients' wellbeing and whereabouts. She was alone. At 0730hrs, she was found lying on the floor of the bedroom corridor outside X's room with stab wounds to her upper back. The alarm had been activated a few moments before from inside X's room. A Medical Emergency Response Team (MERT) call was made and staff commenced resuscitation. X was reportedly in his bedroom with the door closed and locked from the inside. He had covered the window in the door, as well as the CCTV camera in the room.

5.2. Unit staff began resuscitation attempts for Ms W; the Ambulance first responder arrived at 0734hrs; police arrived at 0740hrs as did a second ambulance. Staff also made a call to the GHT switchboard for a psychiatric emergency team to extract X who was still in his room and apparently had a weapon. Police detained him at 0754hrs. The ambulance carrying SW arrived at GHT Emergency Department at 0803hrs but, sadly, she was pronounced deceased shortly afterwards.

5.3. Staff moved other patients from Montpellier to other points in Wotton Lawn Hospital. X was assessed in Custody in Gloucester by the Montpellier Consultant Psychiatrist, the Approved Mental Health Professional (AMHP) attached to the Criminal Justice Liaison Service (CJLS) and the Crisis Team Lead. He was calm at this time and did not appear disturbed; he did not show any signs of psychosis and did not offer any explanation for his actions.

5.4. An account of the contact made between senior Trust staff and the family of Ms SW can be found in the internal report. It appears that this was managed in a sensitive and responsible manner, including by contact with the police appointed Family Liaison Officer and over the course of 2014 as the various investigations progressed. A UNISON solicitor

assisted the family and an NHS Litigation Authority payment was finalized. Questions were addressed when the family raised them about, for example, locked doors, arrangements for unescorted as against escorted leave, use of the unit car and, importantly, why Ms SW was alone (which was not unusual or in breach of standard practice) when she completed her morning checks.

5.5. Further detail about the events of this day and the management of the incident can be found in the internal report. There is no reason to believe that the staff failed to deal with it in a prompt, professional and speedy manner.

6. Findings

6.1. In this section, for ease of reference, findings from this investigation are presented in the order that the Terms of Reference (Appendix 1) sets them out. Appendix 2 contains a list of recommendations made in the internal report to which these refer.

The care, treatment and services provided by the NHS, and its appropriateness in the light of M's health needs (focusing on the most recent and relevant period)

6.2. Our investigation team examined carefully the evidence from case records, staff statements made in 2014 for the internal report and correspondence relating to the care and treatment provided for X during his time at Montpellier. Staffing levels were good in 2014 and staff training and qualifications were appropriate. X's care package included psychology, health and well-being, physiotherapy, occupational therapy, and input from nursing and psychiatry. Appropriate records of this were kept, which are clear and easy to follow.

6.3. Our team found no evidence to believe that the mental and physical health care and treatment provided at Montpellier for X was not provided to a good standard. Furthermore, whilst the internal report makes twenty recommendations (see Appendix 2) only two specifically related to the content and quality of clinical care; one (R18) relating to relatively low levels of clinical psychology input (now remedied) and the other (R4) relating to the extension of programmes to promote healthy living (also now remedied). In this regard, our team is pleased to confirm findings from the initial investigation that the quality of care provided was good.

6.4. Our team spoke to staff providing care currently at Montpellier; we looked at current case records and obtained an understanding of the team's philosophy and broadly

rehabilitative approach to providing care for some very challenging individuals. We were impressed with the quality of the care provided, and with the quality of the highly motivated well-led clinical team. Several changes have been made since 2014 which strengthen the service further. For example, notes of discussions at multi-disciplinary meetings are now recorded contemporaneously in the patients' notes rather than afterwards. Links to Care Plans and Risk Assessments can also be found here rather than under the pre-set RiO[4] tabs. Whilst this is potentially confusing for those new to the system who might expect to find a care plan or a risk assessment under the tab with the relevant label, this apparently makes access to these documents easier for the team.

6.5. Whilst some junior staff in 2014 complained to the Stage 2 investigators that they were not always listened to and some reported a rather `top down' culture which made it difficult for them to express their concerns, this issue has also now been addressed. Junior staff such as Health Care Assistants are included in the multi-disciplinary Team Meetings and the Unit Manager, whilst she has an extensive range of administrative duties which tie her to the office, is now much more `visible'. Other changes introduced since 2014 include a plan of training in the management of patients with Personality Disorder that has been implemented and is now being delivered by the clinical psychologist attached to the unit (R3).

6.6. A recommendation (R9) to appraise the options for moving the Unit manager's office downstairs within visible distance of staff and patients has also been addressed. Whilst it proved impossible to physically move the office, the Unit Manager now personally completes two shifts per month working clinically with the team; staff take meals with the patients which helps to reduce potential social and professional distance, and staff groups and a `community' meeting have been established for concerns to be aired.

6.7. The investigation team commends the Unit for making these changes. However, we remain somewhat concerned that the grade (Band 7) of the Unit Manager's post is set at a relatively low level given the extent of her other administrative and clinical duties. Whilst the performance of this postholder is not being questioned (indeed, the postholder is doing an impressive job), the team was concerned about the risks of replacement in the event of the postholder's departure. The workforce research literature is increasingly focused on concepts such as `occupational stress' and `work strain' which have been

[4] RiO is one of the Electronic Health Record systems used since 2008.to hold NHS case records that were formerly paper based.

shown[5],[6] to have a relationship with mental as well as physical ill health amongst staff, as well as a close, if indirect, relationship with care quality. In the current economic climate, it is important that employers improve productivity and reduce inefficiency, but because it is also challenging to attract and retain staff, our team urges the Trust to review the grading structures and staffing levels at Montpellier where the staff team does a difficult job in a very challenging environment.

The adequacy of risk assessments and risk management, including specifically the risk of the service user harming others

6.8. The internal report made six recommendations (R8, R10, R11, R12, R14 and R16) relating to the assurance of risk assessment and management, use of CCTV, separating other patients safely from an incident, internet access, searching patients and visitors, and the use of standardized approaches (such as HCR20) to the assessment of individual risk.

6.9. Our investigation team was able to confirm the findings of the Stage 2 investigation which, on the basis of interviews with staff and a careful look at the clinical records, appropriately outlined X's risk profile. His risk of suicide had been assessed properly on Monday July 7th as follows: Suicide: medium; Self harm: medium; Absconding: low; Violence: medium (due to the nature of his 1983 offence); self-neglect: low; exploitation: low; and vulnerability: low. There was no evidence to suggest that staff missed anything significant.

6.10. It is not known how X obtained the knife that he used since it did not come from within the Unit. Possibly, he obtained it whilst out on leave in the town. It is also possible, as X had been sleeping in his clothes for a few days prior to the planned move, that the knife had been secreted about his person. However, as the Unit search policy did not (and does not now) support the use of random searches or searches of patients unless there is reasonable cause, the weapon had not been detected. Furthermore, whilst it is the case that illicit items had periodically been found in X's possession in the past, there had been no evidence of violent behavior since 2010 when it was damage to property rather than to persons that he inflicted.

6.11. Since 2014, in partnership with those leading the HSE investigation who were primarily concerned with staff safety, the team at Montpellier have thoroughly overhauled their

[5] Vincent CA (2001). `Clinical risk management: enhancing patient safety'. 2nd edition. BMJ Publications
[6] Siegrist, J et al (2009) `Employment arrangements, work conditions and health inequalities: report on new evidence on health inequality reduction produced by Task Group 2 for the Strategic Review of Health Inequalities post 2010.' www.ucl.ac.uk/gheg/marmotreview/

policy in all areas relating to risk. For example, in the summer of 2015, the Director of Quality set up a 'positive and safe' subcommittee, reporting to non-executive directors through the governance committee, chaired by the assistant director of governance and compliance. A range of issues were (and are now) addressed. These included methods to improve the quality of data collected on the use of prone restraint incidents to better understand where and when they occur, which patients are most commonly affected, and how to prevent harm. A new version of the Datix incident reporting system to improve data accuracy was developed, and a case study of this work was published by NHS Improvement in June 2017[7].

6.12. Changes have also been made to improve staff training in risk assessment and management. Steps have been taken to upskill doctors and Band 5 and Band 6 nurses and patients at Montpellier are routinely screened using the HCR20 as recommended in the internal report and the Structured Assessment of Protective Factors for Violence Risk (SAPROF). The latter is a violence risk assessment tool specifically developed for the assessment of protective factors in adult offenders with violent offending histories as well as for people who have previously sexually offended. It is intended to be used in addition to risk focused Structured Professional Judgment assessment tools, such as the HCR20 assessment. Whilst there is a continuing debate in the clinical and academic literature about the usefulness of structured tools as against narrative clinical reports to assess risk, our team believes that the decision to include SAPROF as well as HCR20 was sensible and helpful and the use of both narrative and structured tools is entirely in line with best practice and current guidance.

6.13. Access to the internet by patients has been reviewed in line with the recommendation (R12) in the internal report and a system called `Barracuda' has been installed. This is a web security gateway that apparently incorporates malware and virus protection with a policy and reporting engine that restricts access to or permits information to be provided about access to, for example, social networking sites such as Facebook or Twitter. Whilst staff report that Barracuda is not a perfect means to restrict access to inappropriate or banned sites (and it can potentially be overridden) it is a significant improvement.

6.14. CCTV camera coverage has also been improved following a recommendation (R10) in the internal report relating to the fact that coverage of M's time in the garden/outside area the evening before and on the morning of the incident was poor.

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[7] https://improvement.nhs.uk/resources/improving-quality-and-safety-healthcare-safety-mental-health-trusts/

The effectiveness of the service user's care plan, including the involvement of the service user and family.

6.15. In 2014, individualized care plans were written in consultation with the patient based on the `My Shared Pathway' model. X had such a plan; it was fully appropriate in view of his history and the intention to support his rehabilitation through to lower levels of security and, ultimately, his discharge from his Mental Health Act Section and detention. He had a `Pathway Coordinator'; there was an identified clinical lead in place, and risk assessments linked to the Care Plan were in place. X had been supported to visit his mother in her care home during his time at Montpellier. He had no other family with whom to make contact since X's daughter (S) had made it clear some time before that she wanted nothing more to do with him.

6.16. After the incident, the Trust lead for Safeguarding visited X's mother at her care home. She was told that her son was in police custody and that the Trust would undertake an investigation. A letter was also written explaining the Trust's investigation processes and inviting her to contact the Trust, with the assistance of the Care Home Manager, if she wanted to discuss the findings with Trust Executives. She did not get in touch and has since passed away.

The lead up to discharge arrangements being put in place and the appropriateness of the service user and staff involvement

6.17. Our team sought clarification and elaboration of the arrangements put in place to transfer X on the 9th July to Ty Catrin, the day that the tragic death of Ms W occurred. There were three areas of enquiry: a) the decision to move X to Ty Catrin and how this was made; b) the extent to which agreement had been secured with X, and c) the extent to which staff knew and/or agreed with the plan to give him only very short notice of his departure.

6.18. It is clear from the case notes and records of discussion at the multi-disciplinary team meeting that the decision to move X to Ty Catrin was broadly appropriate and was consistent with X's stated wish by that time to leave Montpellier. It is also clear that X was involved in an appropriate way in the decision which was discussed fully with him. A visit by X to Ty Catrin was arranged on 5th June after which he had initially been positive. He packed a bag and discussed arrangements with a HCA to escort him to say goodbye to his mother. However, as time went on, X seemed to change his mind; he said he did not like the restrictions imposed upon patients at Ty Catrin to access the internet or the fact

that there was apparently an expectation that he would remain there for at least a year. These concerns mirrored to some extent the concerns that X had expressed about an earlier suggestion (October 2012) that he might move to Knole from Montpellier. Knole is a Unit in Cheltenham run by the Langley House Trust that provides social care for men with histories of offending and takes restricted patients.

6.19. It would not be unusual for multi-disciplinary teams to fail to reach a completely unanimous decision about a course of action. Indeed, once X's advocate learned of X's opposition, they argued at the multi-disciplinary team that a further placement should be found for him. However, the decision to continue with the move to Ty Catrin was agreed and our team found no reason to disagree that the decision was in X's best interests. Whilst planned transfers had in the past provoked some objections by X (e.g., when the move from Chadwick Lodge to low secure care was proposed in 2009 and 2011) he had tended to settle, at least for a while before (e.g., at Chadwick Lodge, Thornford Park, Montpellier, Knole and Ty Catrin) he fell out with staff; perceived them to be unjust or found the social environment unacceptable. It is certainly possible that his long-held belief that he might be killed in revenge for his index offence lay at the root of his concern.

6.20. Somewhat more difficult to endorse is the decision to delay telling X about the arrangements until the day before his departure. It appears that this was done to minimize the chances he would plan some form of sabotage or protest. Furthermore, not all the staff appeared to be aware of the decision and this was less than good practice given the importance of ensuring that communications with X were consistent. A transfer checklist has now been designed (R15) to promote a more structured approach to the follow-up and implementation of decisions to transfer patients. A similar checklist has been developed for admissions to ensure that all relevant information is gathered and shared.

The Trust search policy and practice in the light of best practice and national policy

6.21. Work has been undertaken at Montpellier to review policy on searching patients (R1 and R2) and visitors to the Unit. The Unit Consultant Psychiatrist with colleagues in the Trust published a paper about their work on the effectiveness of a range of commercially available metal-detection devices which showed unexpected variation in their performance, particularly in relation to smaller metallic items. The entrance to the Unit is now equipped with the most appropriate and up to date technology.

6.22. Policy on searching patients and visitors was overhauled and refreshed and new policy guidance was issued in August 2016 to the Psychiatric Intensive Care Unit (PICU) on the

Wotton Lawn site and to Montpellier. Consistent with the Mental Health Act Code of Practice, this does not apply a `blanket approach' to searching or restricting patients' activities. Staff must hold a `reasonable belief' that 'intrusive' interventions/searches are necessary and be able to identify the level (there are three) of searches that are appropriate. The policy is robust; it is in line with national policy[8] (which does allow for random or routine searches in low secure settings) and it has been communicated effectively to the staff team as part of their routine training.

Progress in implementing the recommendations from the internal investigation

6.23. As will be clear from the above, our team believes that progress in implementing the twenty recommendations from the internal Stage 2 investigation has been good. Governance of the process has been thorough, and the Trust Board has maintained oversight of the changes, many of which go far further than the recommendations alone would necessitate. Our team has no reason to doubt that that the care provided at Montpellier is effective, safe, and accords with best practice in units providing low secure services.

6.24. However, our team had a concern which we would like to highlight. The internal report (see internal report: `Recommendations for Shared Learning' Section 19, p. 87) lists the key individuals and organisations with whom the authors recommend the report should be shared. The list includes staff at Montpellier. However, many of the staff were not allowed to see the internal report at the time it was submitted and it has still not been widely shared (although its recommendations and the Action Plan have been).The Chief Executive, the Governance Team and the Consultant Psychiatrist were very clear that, at the time, the lead investigator for the HSE investigation made a request that it should not be shared, at least for the duration of his work. Our team clarified with a senior representative at the HSE that this request was made to ensure that the publication did not prejudice the investigation any potential legal proceedings.

6.25. Unfortunately, this decision, coupled with the fact that feedback (verbal) about the outcome of the HSE investigation was not presented to the Trust until October 2016 meant that staff, contrary to their expectations, were left with only very limited information for a very long time. Not only were most staff unaware of the narrative of the internal

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[8] https://www.cqc.org.uk/sites/default/files/20170322_briefguide-use_of_blanket_restrictions_in_mental_health_wards.pdf

investigation, they were not given copies of their HSE interview transcripts (as they thought, perhaps erroneously, would be forthcoming) and, when the HSE reported in October 2016 that no further enforcement action was warranted, they reported feeling let down.

6.26. In fact, the Chief Executive did communicate with all staff when the Notice of Contravention (NoC) was initially received (March 2015) and when the HSE reported to the Trust Board in October 2016. However, the length of time taken by the HSE, clearly due to the complex nature of the investigation, meant there was a long period without effective closure for staff regarding the tragic events of 9th July which led to the death of a friend and colleague. For some, their questions, for example, about failures of care or blame that might fall to them personally were never effectively answered; others left the service before the process was finalised.

6.27. Clearly, the HSE has an obligation to maintain the integrity of their investigations and cannot provide a running commentary on outcomes until the process is complete. However, the restrictions on information sharing meant that Trust senior staff were also unable to provide the personal reassurance that might have helped to mitigate the risk of speculation, self-examination and interpersonal blame that, amongst some staff, set the scene for a prolonged period of mental distress.

6.28. It is not surprising that several of the remaining staff with whom our team spoke were still shaky and tearful over three years later. It is a credit to them that they were prepared to speak with us at all. Whilst we are aware that appropriate support (counselling in some cases) was provided to them at the time, it is very important that commissioners of investigations and those with responsibility for leading them bear in mind the longer-term risk that the process of investigations can hinder rather than help recovery. Secondary traumatization is a very real concern.

Whether the incident was predictable and preventable

6.29. Together with evidence gathered during our investigation about the quality of care that was provided for X, our team does not believe that the incident which resulted in the tragic death of Ms SW could have been predicted or prevented.

6.30. Prediction and prevention of tragic incidents such as this are a very complex challenge. On the one hand, there were factors in this case which statistics suggest should make prediction easier or more accurate. For example, X had already been found guilty of two counts of murder; he had an early life characterized by violence; he

had been diagnosed with Dissocial/Anti-social Personality Disorder; he had a history of paranoid schizophrenia and he was disinclined to take a full dose of medication. Furthermore, it was known that he was reluctant to go to Ty Catrin and that he had issued veiled threats about the consequences if he did.

6.31. On the other hand, X had not behaved violently towards anyone for almost thirty years; his only violent episode during that time (in 2010) involved damage to property not persons; there were no signs that his mental health was deteriorating, and there was no evidence that he bore any ill will towards Ms SW personally. It seems to be the case that X attacked her randomly and that he may have done this to secure a return to prison to avoid the move to Wales.

6.32. As to the question of whether Ms SW's death failed to be prevented as a result of failures in the care system, our team believes that the Trust took all reasonable steps to avoid a violent incident. Prevention means to `stop or hinder something from happening, especially by advance planning or action' and implies `anticipatory counteraction'; therefore, for a homicide to have been preventable there would have to have been the knowledge, legal means and opportunity to stop the incident from occurring.' Appropriate policies and systems were in place; a risk assessment had been completed; it was known from previous moves that X would probably settle and although it is unlikely that shortening the notice for X's move would lessen his personal motivation to go, it potentially made the move easier for staff to manage.

6.33. It is possible that X was more mentally unwell than he appeared. However, the assessment that was completed immediately post-incident did not uncover any signs of this. Indeed, signs of a psychosis did not emerge until eighteen months after X was transferred to prison. The incident therefore appears, with hindsight, as unexpected as it was experienced to be at the time.

6.34. The HSE did identify areas for improvement in how the Trust manages the risks of violence and aggression, and in lone working and search policy and procedures. However, in October 2016 the HSE stated there was insufficient evidence that the Trust fell below expected standards to warrant further enforcement action. In their verbal feedback to the Trust, the HSE indicated that they were not able to say that shortcomings in these areas were causative of the tragic death of Ms W. In this, their conclusion mirrored that of the internal report, and our own.

7. Conclusion

7.1. This is the report of an independent investigation commissioned by NHS England into care and treatment provided by 2Gether NHS Mental Health Foundation Trust (`the Trust') for `X' who was in receipt of care by the Trust when he killed Ms W, a Health Care Assistant, on 9th July 2014 at the Montpellier Low Secure Unit. Ms. W. was fulfilling her early morning observation duties when she was stabbed twice in the back with a kitchen knife that X had obtained and concealed. On the basis of a review of information obtained from staff and an examination of documents, policies and procedures, our team does not believe that the tragic incident which resulted in the death of Ms W could have been predicted or prevented.

7.2. We would like to extend our sincere condolences to Ms W's family for the tragic loss of a much-loved wife and mother. We hope that our report will help them to understand the background to the care that X received, and the steps that have been taken since then to strengthen services.

7.3. Our investigation team is pleased to report that the recommendations made to strengthen services by an internal report and by the Health and Safety Executive after their investigation which was completed in 2016 have been implemented in full. We would like to commend the staff team at Montpellier for the delivery of what appears to be a very good standard of safe and effective care. Safety and risk issues are taken very seriously: risk assessment and management systems (standardized clinical tools, CCTV, search policies and practice, policies relating to internet use, etc.) are in place and working well. Furthermore, there is a healthy culture of care which is individualized and rehabilitative in its focus. The team is well-led and the staff report feeling supported and well-trained.

8. Recommendations

8.1. Our team has three recommendations to make.

8.2. The first concerns the importance of ensuring that staff at Montpellier have the opportunity to see this report and discuss, if they wish, any points arising from it. We will arrange an opportunity to do this.

8.3. The second recommendation is for the Trust to review the structure of the staffing arrangements to ensure that an appropriate balance of trained and untrained, senior

and junior staff is available to deliver the best quality of safe care in what is a very challenging environment. We will follow this up in six months' time.

8.4. The third recommendation concerns the importance of maintaining awareness of risk, and of action to reduce the risk that staff are so affected by the process of investigation(s) that their mental health, commitment and quality of service delivery are potentially affected. We recommend that investigators should always be mindful of this, should ensure that effective communications are provided for staff about progress and any emerging outcomes, and liaise with the Trust staff to signpost staff on an individual and/or group basis for support as needed.

APPENDIX 1

Terms of Reference for the investigation (ref: 2014/22374)

This case has been the subject of both an internal investigation and a Health & Safety Executive investigation. The Health & Safety Executive has decided not to pursue their investigation and have, therefore, not produced a report but is happy to share what they can from their investigation.

The independent investigation should build on both the internal and Health & Safety Executive investigation and utilise the intelligence from both. A meeting with the Health & Safety Executive should be set up at the beginning of the investigation to gather the intelligence from their investigation.

The focus of the investigation should be on present day services and current processes.

- Review the care, treatment and services provided by the NHS from the service user's first contact with services up until the time of the incident on 9 July 2014, focusing on the most recent and relevant period.
- Review the appropriateness of the treatment of the service user in the light of any identified health needs.
- Review the adequacy of risk assessments and risk management, including specifically the risk of the service user harming others.
- Examine the effectiveness of the service user's care plan, including the involvement of the service user and family.
- Examine the lead up to the discharge arrangement being put in place and the appropriateness of the service user and staff involvement.
- Review the Trust search policy and practices and consider these in light of best practice and national policy.
- Review the progress the trust has made in the implementation of the recommendations from the internal investigation.
- To consider if this incident was predictable and preventable
- Provide a written report to NHS England that includes measurable and sustainable recommendations
- Assist NHS England in undertaking a brief post investigation evaluation
- Undertake a six-month review of implementation of recommendations detailed in the report and produce a summary for the families.

APPENDIX 2

Recommendations made in the internal report

R1 The Trust's Search Policy will be reviewed to recognise the specific requirements of low secure care and PICU supported by a training programme. The Search Policy will explicitly outline local procedures including:

- A written procedure for searching visitors to the Montpellier Unit and PICU
- The identification of staff who are authorised to undertake searches, with this competency recorded on the mandatory training requirements
- A written procedure detailing how to undertake a search of a person A written procedure detailing how to undertake a thorough search of property and rooms

R2 Practical training to be provided to identified staff, including competency assessment on the implementation of the policy and specific procedures, with the frequency of refresher training being stipulated. Implementation of the revised Search Policy will be subject to clinical audit during Quarter 3 2015/16 to establish effectiveness of implementation. The audit will focus specifically [to] review practice in the Montpellier Unit, PICU and two adult acute wards. It will include all elements of compliance with the:

- procedures for searching visitors
- procedures for searching property and rooms
- documentation relating to the identification and training of staff authorised to undertake searches, and their assessment of competence
- documentation of searches that have been conducted.

R3 A unit-specific training needs analysis for the staff on the Montpellier Unit will be developed and a training programme implemented. This will focus on the specific needs of low secure care and the needs of the patients supported in that setting bearing in mind their dual relationship with the Criminal Justice System:

- risk assessment,
- searching
- personality disorder, and
- the management of complex service users.

This training programme must include both registered and unregistered staff and be subject to organisational level monitoring for completeness.

R4 The Unit will review its programme of training and supervision around the promotion of healthy living programmes, and its application to individual choice and dignity

R5 The Unit will ensure that staff are trained in and apply the Regional Low Secure My Shared Pathway for patients in the Montpellier Unit to provide assurance

R6 The Montpellier Unit Manager will ensure that clinical and managerial supervision, appraisal and staff training requirements are compliant with defined Trust standards and report on this monthly to the Countywide Service Director.

R7 The Unit will agree a plan for the development of the Unit team, particularly reflecting the recruitment of new team members. This will include:

- Team reflection and review
- Team building
- Opportunities for unit staff to experience other areas of recognised best practice care within the low secure environment.

R8 A programme of clinical audits will be developed to provide assurance regarding forensic mental health risk assessment and care planning.

R9 There will be an option appraisal developed regarding the potential relocation of the unit manager's office arrangements to downstairs within visible distance of staff and service users.

R10 The Trust will review the measures (including use of technology such as CCTV) to safely observe and support service users in the unit garden area that will enable consistent observation and maintain staff safety and well-being.

R11 The Trust will develop guidance (which may include locking doors) to enable patients to be safely separated from an area of clinical activity where urgent treatment/intervention is taking place

R12 The Trust will develop specific guidance regarding the use of internet access on the unit with reference to the issues identified in this report.

R13 The Practice Guidance Document will be indexed and reviewed for consistency and application including processes for review and access, and approval by the Locality Board.

R14 The following policies will be reviewed for consistency and application in the light of this serious incident:

- Searching of Patients
- Observation Policy

- Violence and Aggression Policy
- Incidents Involving Hostage Taking
- Service User Internet access
- Security Policy

R.15 A checklist will be developed to support future patient transfers and applied.

R.16 There will be a review of the application of appropriate standardised approaches for assessment of risks and guidance for their routine use such as but not exclusively, HCR20.

R.17 The unit documents and files MDT notes and records within the RiO electronic healthcare record within the progress notes to ensure that they can be accessed by clinicians in a timely way.

R18 The Trust will review the available provision of psychological therapy time available to the unit to be able to adequately support its commissioned purpose.

R19 The Trust will develop and implement a defined, measurable process regarding unit/ward walk rounds at times of handover to ensure engagement of patients and support for staff.

R20 The Trust will commission a review of the approach to the maintenance of staff safety in order to develop a specification to be addressed in the design, delivery and development of services. This will reflect a balanced recognition of the risks and benefits to staff and patients whilst addressing other responsibilities as an employer.

APPENDIX 3

Investigation team

Anne Richardson, Director of ARC, is a clinical psychologist by training; she specialized in work with adults with severe mental ill health and long-term needs. As head of mental health policy at the Department of Health she was instrumental in the development of the National Service Framework for Mental Health and for the development and delivery of the national learning disabilities inquiry `Healthcare for All' (2008). Anne has worked on a number of investigations into the quality of NHS care and treatment provided for people who lost their lives unexpectedly, or for those who were themselves responsible for a death whilst in contact with services.

Hugh Griffiths is a former consultant psychiatrist in the North-East of England where he carried responsibility for in-patient and community psychiatry for adults, recovery and rehabilitation for people with severe and long-term mental disorders, as well as liaison services in general hospitals. As Medical Director of the Northern Centre for Mental Health he was responsible for the development of guidance on changing roles for consultants, support for medical managers, and clinical leadership of the Mental Health Collaborative. Latterly, as Deputy and then as National Clinical Director for Mental Health (England) at the Department of Health he led the development of the Government's Mental Health Strategy "No Health Without Mental Health" (2011) and was instrumental in its subsequent Implementation Framework.

Dr Ahmad Khouja is a practicing consultant psychiatrist with over 15 years working in forensic psychiatry. He is the Senior Clinical Director of Forensic Services and Deputy Medical Director at Tees, Esk and Wear Valleys NHS Foundation Trust, with clinical and operational responsibility for a range of services including medium and low secure, prison offender health and forensic community services. He is the Trust lead for clinical risk assessment and has led a cultural change in moving from a risk-averse approach to risk assessment to one focussed on recovery and harm minimisation. He is a former member of the NHS England Clinical Reference Group for High and Medium Secure Services, and has been involved in writing national service specifications for secure services. He is a registered Court Expert for the Court of Protection in matters of assessments of capacity, with extensive experience in the writing of criminal and civil reports.

Adrian Childs started his career in Surrey in the mid-1980s, training as both a general and mental health nurse. He has been a director of nursing at Newcastle, Northumberland and North Tyneside Mental Health Trust and earned a distinction in his MSc at the University of

East London in the mid-1990s. Adrian also holds a diploma in leadership, mentoring and executive coaching. Adrian established matrons' posts at the Manchester inpatient sites, developed professional heads and communications pathways, and oversaw the strengthening of governance system and processes. Adrian has contributed to several national working parties including the development and appointment of Consultant Nurses and development packages for nurses working with severe personality disorders. His previous experience includes serving as deputy chief executive and director of nursing at Devon Partnership NHS Trust and Newcastle, Northumberland and North Tyneside Mental Health Trust. Adrian is currently working as Director of Nursing at Leicestershire Partnership Trust. In 2014 Adrian was made Honorary Professor for the Faculty of Health and Life Sciences at De Montfort University, Leicester. As a member of this investigation team, Adrian will lead on all aspects relating to the nursing process and to the management of patients with personality disorder.

Richard Mizen MA, DSW, CQSW, trained as a Social Worker and subsequently as a Psychoanalytic Psychotherapist and Jungian psychoanalyst. As a Social Worker and then social work manager he worked in Adult Mental Health, Child Protection and Forensic Mental Health. His previous posts include in an Interim (medium) Secure Unit, working with patients being assessed and supported for the move from Special Hospitals to the community, and supervision for staff working in a specialist outpatient service to assess mentally disordered offenders and people judged to present a risk of offending as a consequence of mental health difficulties. Richard has also worked in the public sector/NHS as a psychotherapist. He is currently Programmes' Director for the Doctor of Clinical Practice programme; the MSc in Psychological Therapies Practice and Research (Psychodynamic/Psychoanalytic) programme; the Mother/Infant observation programme and two psychotherapy clinical trainings at the University of Exeter, School of Psychology department of Clinical Education Development and Research (CEDAR). He is the co-author of 'On Aggression and Violence – an analytic perspective' (Palgrave McMillan 2007).

APPENDIX 4

Witnesses

Consultant Forensic Psychiatrist, Broadmoor Hospital.

Consultant Psychiatrist, Montpellier.

Medical Director, 2Gether NHSFT.

SAS and S12 Approved doctor.

The Senior Management Team (LT, MB, GD, RD and SC).

ZB, HM Inspector of Health and Safety, Health and Social Care Services Team, Engagement and Policy Division, Health and Safety Executive.

JS, AG, EM, VB, LD and EM (6 x Band 5 and 6 nurses)

PR, CJ, HP and KP (4 x Band 3 and 4 nurses)

PR, ST, GF and AC (4 Health Care Assistants)

The Governance Team (MC, ME and GB).

APPENDIX 5

Trust policies and other documents reviewed

Report into the Homicide of a Member of Staff (STEIS – 2014/22374) Winterbottom, P., Trevains, J., & Fear, C. The `Stage 2' internal independent report. Submitted 22nd Jan 2015.

Transcripts of witness statements made for the Stage 2 report

Action Plan regarding SI-19-15 Montpellier Unit homicide.

Operating Policy for Montpellier Low Secure Unit.

Observation Policy.

Risk Policy Matrix (June 2017).

Policy on internet access.

Security Policy.

Trust Wide Policy on Assessing and Managing Clinical Risk and Safety in Health & Social Care Practice.

Policy for Searching patients and visitors' property – Psychiatric Intensive Care and Low Secure Units.

Records of staff training 2016/17.

Assessment and Care Management Policy (Incorporating the Principles of the Care Programme Approach).

Papers for the Clinical Governance Committee (July 2014 and January 2015).

NHS Improvement Report (June 2017) `Improving patient safety by reducing prone restraint, through better use of data, targeted training and other improvement initiatives' – a published paper describing good practice at 2Gether NHS Foundation Trust.

Laidlaw, J., Dix, R., Slack, P., Foy, C., et al `Searching for prohibited items in mental-health hospitals: A randomized controlled trial of two metal-detecting technologies' (2017) Medicine, Science and the Law. 0(0),1-8.

sagepub.co.uk/journalsPermissions.nav

A random sample of six electronic clinical notes for patients at Montpellier.

HSE `Regulation of Health and Safety at Work' (2014)

www.hse.gov.uk/pubns/hse51.pdf

HSE Enforcement Policy Statement (October 2015)

www.hse.gov.uk/pubns/hse51.pdf

HSE Letter to Trust received 22nd February 2017

Letter (Oct 2016) to Trust staff from the CE containing feedback about outcome of the HSE investigation

Trust Board papers: the closed meeting 29 Jan 2015 at which the internal Stage 2 report conclusions and recommendations were discussed and actions and monitoring agreed.

Trust electronic records of actions to follow up on recommendations.

APPENDIX 6

Chronology of contact with health and criminal justice services

DATE	CONTACT
1965	X was reported to have had extensive contact with criminal justice services at age 13/14 for violence, sexual offences, burglary and theft. He was also in contact with Child Guidance.
1969	At age 17, X was convicted of ABH after slashing his sister's boyfriend's face with a knife after he allegedly hit her.
1970	X was convicted of unlawful sexual intercourse with a minor.
1972	X was convicted of possession of an offensive weapon (a knife). He met (D), 2 years younger, whom he married at age 20. There was a daughter from this marriage (S) who was born whilst X was in Borstal. The marriage ended after a year
1973	After his release from prison, X abducted his baby daughter (S) and threatened to kill her (they were subsequently estranged). There was a second episode in which he disappeared with the child when she was 18 months old; on both occasions Social Services were involved in negotiations to have the child returned, which she was.
1978	X's ex-partner (D) reported that X's mental state had changed around this time; that he became psychologically intimidating; he said he could read her mind and was possessed by the devil. The relationship ended, but no contact with mental health services was made.
1980	At the age of 28, X moved to Devon and met (W) who had a daughter (P) but a violent incident at the house of his parents-in-law led to this relationship breaking down and X was arrested.
1981	X was convicted of criminal damage with a hammer to the home of his girlfriend's parents and for firing an air rifle in breach of his Probation.
1982	At age 31 X broke into a warehouse with two co-offenders to steal a quantity of silver bullion. When one of the three was picked up and then released by the Police, X and his co-offender killed him. Fearing that his 16yr old daughter would inform the police of their identities, they also killed her.
1983	X was convicted with another man at Exeter Crown Court on two counts of what the judge described as `utterly callous and cold-blooded' murder and attempted murder. Threats were made at this time to X and his co-conspirator by the family of the two people they killed. X was sentenced to life imprisonment with a minimum duration of 25 years. He began his sentence at HMP Wormwood Scrubbs. After three years, he was moved to HMP Long Lartin.
1989	X moved to HMP Cordingly where he was noted to be depressed and isolated. After a year, he was transferred to HMP Maidstone where he was described as having thoughts of being possessed by the devil. X also reported smoking cannabis at this time; he said it made him paranoid, suspicious and fearful for his life.

1991	X (now aged 40) was segregated from other prisoners due to concerns about his mental state; he reported sleep problems, anxiety and low in mood. He reported a (presumed) delusional belief that he would be killed by another inmate whose daughter he believed he might have raped in the past. He was placed on suicide watch but refused treatment. He was moved to HMP Parkhurst and then transferred to Broadmoor Hospital in October under Section 47/49 of the MHA presenting with a range of bizarre delusional and paranoid beliefs.
1991-6	X remained at Broadmoor for five years, His symptoms resolved on treatment with anti-psychotic and antidepressant medication. Psychological intervention at this time focused on X's risk of sexual violence. In 1993 X broke off contact with his daughter, S.
1996	X was returned to HMP Parkhurst but relapsed when he stopped taking his medication.
1999	X was returned to Broadmoor. Under Section 47/49 of the MHA.
2003	X consented to take anti-psychotic medication on a regular basis and by the end of this year, he was well enough to consider stepping down to medium security. The Home Office agreed to a trial period of leave.
2004	X was given trial leave at Chadwick Lodge, a Medium Secure Unit (Priory Group) providing specialist treatment for patients who have been detained under the Mental Health Act and have a history of offending. The following year (2005) X moved to Chadwick Lodge where he remained for 7 years, receiving psychological treatment focused on identifying early warning signs of a mental ill health relapse. However, this ended after 12 weeks as X apparently found it too anxiety-provoking. Risk assessments completed around this time emphasize the difficulty that X experienced expressing and managing his emotions (especially anger); mistrust of women, and his social isolation.
2007	X suffered a relapse of his psychotic symptoms; he thought other inmates and people in the community (when out on visits) were trying to kill him. He reported that the family of his earlier victims had paid someone to kill him. At this time, X also neglected his personal hygiene and gave a report of attempting suicide.
2009	In June 2009, as X seemed to be making good progress and was consenting to treatment, a MHRT decided that it would be appropriate to move him towards a community rehabilitation programme.
2010	In August, X suffered a heart attack; it appears that this was treated appropriately by the mental health services. X then fell out with hospital staff after being falsely accused of breaching the boundaries of his leave (it was a case of mistaken identity). He smashed a tv and was moved back to medium secure detention. At the time, X said that the move had been his own choice.
2011	In a report to the Parole Board in March, the consultant psychiatrist with responsibility for X's care did not feel he was yet ready to be released, largely due to his fluctuating level of insight and the fact that he had not engaged fully with treatment. He said X told him that "since he has done nothing like the incident in which he smashed the TV in the lounge this week during the previous 29 years that the MoJ would sit up and take note." The report noted a degree of hostility towards the environment and staff and speculated

	that this may have been in the context of a consideration around moving to Thornford Park Low Secure Unit.
	In May 2011 X transferred to Thornford Park Hospital in Berkshire – a low secure facility, also part of The Priory Group. Whilst here, X was assessed by staff at the Montpellier Unit (also low secure) to extend the focus on his community rehabilitation.
2012 June	X transferred to Montpellier on Section 47/49 of the MHA, a move that he was apparently keen to make, and the notes describe that this was a positive experience initially. There were 10 other patients on the Unit at the time. Staffing levels were good. Plans were initially made to allow X to have 30 minutes of leave (normal for a new arrival); his care programme was agreed, and a routine established. X's diagnosis was given as paranoid schizophrenia. Notes also describe X as also showing some characteristics of anti-social/dissocial personality disorder; a diagnosis that was formalized in the notes the following year. X's (self-administered) psychotropic medication was an anti-psychotic (Quetiapine 300mg); what the consultant called `a middling dose'. Other medication at this time included drugs for high blood pressure and high cholesterol. The summary of risk available in the notes describes X's continuing lack of insight and the importance of medication to maintain his stable mental state
2012 July	The notes record X as having fallen out with an Occupational Therapy Technician (OTT) over a disturbance at night.
2012 August	The notes record good progress. X began to engage with psychology sessions although he continued to have disagreements with the OTT. Periods of unescorted leave for half an hour were agreed.
2012 September	Unescorted leave was extended to four hours and plans began to be made to move X to Knole – a unit in Cheltenham focused on rehabilitation for ex-offenders. After initial enthusiasm, X began to express doubts about the placement, largely due to the fact that residents had very restricted access to the internet; according to X it was `full of paedophiles', and residents were expected to stay there for 12-18 months.
2012 November	X decided he did not want to go to Knole and was experiencing a significant amount of anxiety about a parole board hearing due to be held shortly. In the event, the Board decided not to releaseX. He was disappointed and frustrated by this.
2012 December	X breached his agreement regarding use of the internet by befriending two women from the USA on Facebook. He also breached his leave arrangements.
2013 January	X had two further altercations with the OTT and the notes record a discussion of X attempting to `split' professionals' opinion.
2013 March	A MHRT recommended that X be conditionally discharged from his Section, subject to the views of the Parole Board. Consideration was given as to whether he should therefore go back to prison but, as it was thought X would probably relapse in prison, it was agreed that he should remain.
2013 April	X changed his name `to make a fresh start' and appropriate arrangements had to be made regarding security and records to ensure that risk assessment and management could be undertaken. There was a Unit-wide search for missing scissors which led to

	`items of concern’ being found in X’s room (a metal spatula, nail clippers and tubs of vitamin tablets). X subsequently isolated himself, was clearly annoyed, and his leave was suspended for three days. A leather hole punch was also subsequently removed from his possession.
2013 May	Notes record a discussion at the ward round/team meeting about the scope to reduce X’s medication owing to his reports of adverse side-effects and the absence of any signs of psychosis. By the end of this month, X told the psychiatrist that he was planning to stop taking his medication altogether; that he’d only agreed to it as a basis for going to Broadmoor, which was preferable to prison.
2013 June	Notes record a deterioration in X’s mental state. A Second Opinion Approved Doctor (SOAD) was requested. X’s leave was suspended for four months. He made a formal complaint about his care and treatment, including about the way that staff drove cars and knocked on doors at lunchtime to alert patients to go to the dining room. The complaint was investigated but not upheld. X was not happy to allow blood tests, ECGs or his pulse and blood pressure to be taken, even though these were important to the management of his physical health.
2013 July-Dec	X’s mental state and behavior continued to deteriorate. His behavior was also noted to be more challenging; X reported fears that another patient was trying to kill him (he had actually been threatened by someone on the unit who was very unwell) and he refused to take more than 300mg of Quetiapine. X made another formal complaint about a member of staff he alleged had admitted taking drugs. The complaint was investigated but not upheld. In December, there were occasions recorded when X accessed the internet in breach of his agreement and also had access to the internet through a Smartphone in breach of Unit Practice Guidance.
2014 Jan-June	X (now aged 61) continued to challenge staff; he declined to meet with the Unit doctor(s) and was only `reluctantly compliant’ with his prescribed medication; he was not well engaged with activities on the Unit; slept in his clothes and in April and June there were further altercations with the OTT. During April X continued to disengage from services, refused to contribute to his CPA nursing report and declined to see his doctors. On 9 April 2014 the CPA meeting noted that he had not fully recovered from his relapse and still believed that in the past staff and patients wanted to kill him. X then asked to be moved to a different unit and discussions began regarding a move to TyCatrin near Cardiff. Ty Catrin is a low secure unit for people with mental illness and personality disorder who require a medium-term placement and recovery-orientated specialist treatment. X went to visit ion 5th June, and this appeared to go well, though X said he didn’t like the internet policy, the size of the rooms or the smoking arrangements. At the Multi-disciplinary team meeting (MDT) it was agreed that a transfer would be arranged with minimal notice.
2014 July 3rd and 4th	The notes record XM as saying he did not want to go to Ty Catrin and that he would prefer a return to prison. However, he had also packed a bag and seemed to accept that the move would take place. He also told a HCA that the bag would `not be unpacked’

	and said: `I know what I'm capable of.' He requested an escort to visit his mother on July 9th (the day before he thought his move was due) so he could say goodbye to her, which the HCA agreed to do. At this time, X refused attempts to persuade him to take a slightly higher dose of Quetiapine and he complained about staff bullying in this regard. He had also started to sleep in his clothes.
2014 July 8th	Notes record that it was made clear to X on the 8th that he would transfer on the 9th so the planned visit to X's mother was not going to be possible on that day. Notes also record (and they record that it was discussed at the MDT meeting) that X said: `By hook or by crook, I'm going back to prison.' He said he would go on hunger strike if transferred. Later that day, X had a disagreement with the OTT who had stepped in to pick up patients taking leave in the town in the Unit car; X alleged that the OTT had pulled away before he'd put on his seat belt, so he got out of the car and walked. Whilst X had not absconded, it was technically a breach of the rules. He was not searched on his return as searches were not part of his care plan (no previous behavior had indicated any level of need to search him). His risk status was reviewed every Monday and at this point, his risk was as follows: Suicide: medium risk; Self harm: medium; Absconding: low; Violence: medium (due to the nature of his 1983 offence); self-neglect: low; exploitation: low; vulnerability: low.
2014 July 9th	On the morning of 9th July, just after the start of the early shift at 0700, a Health Care Assistant (Ms W, the victim) left the office by herself to complete a round of early morning checks of the whereabouts and welfare of patients. At 0727 the alarm was sounded when Ms W was found outside X's room having been stabbed twice in the back. X's room was locked from the inside; the glass window in the door had been obscured, as had the CCTV camera inside his room. CCTV footage of the garden showed X to have been outside immediately prior to this. At 07.30 the Medical Emergency Response Team (MERT) was called. At 0731 a Staff Nurse dialed 999 and an ambulance arrived at 07.34 and police at 07.40. An emergency psychiatric team was also alerted as staff were aware that X might emerge with a weapon. After arriving at GHT Emergency Department at 0803, sadly, Ms W was pronounced deceased. Staff from Wotton Lawn Hospital assisted in the removal to other wards of the remaining patients from the Montpellier Unit. X was formally reviewed by the Unit Consultant, the social worker and the Criminal Justice Liaison Service and Crisis Team consultant in police cells. There were apparently no signs of psychosis. X appeared to be rational and calm but unemotional during this interview and he recognized his interviewers. He offered no explanation for his actions.
2014 December/ 2015 January	X appeared at Bristol Crown Court by video link where he pleaded guilty to the murder of Ms W. He was sentenced to prison (a `whole life' order).

2015/15	An internal (`Stage 2') independent investigation was undertaken into the circumstances of the death of SW. This was completed in December 2014 and reviewed by the Trust Board on 29th Jan 2015. Unfortunately, owing to the establishment of an HSE investigation (whose lead initially requested that the report should not be shared with staff until their own investigation was complete) many staff were not able to see this report although they did see the Action Plan developed afterwards.
2014-2017	The purpose of the Health and Safety Investigation was to establish whether there had been a breach of the Health and Safety at Work (etc) 1974 Act. Interviews with staff were held and statements prepared; documents and policies were reviewed. By October 2016, this process was complete and verbal feedback was provided to the Trust senior team. The Trust CE wrote to staff to confirm the outcome. In February 2017 a letter from the HSE was received by the Trust to confirm that there had been no breach of the law and that no further action would be taken. No written report (this is usual practice) was provided by the HSE.
2016 September	X was transferred to Broadmoor after approximately eighteen months in prison; he had apparently reported a high level of concern that he would be killed in prison by the relatives of the two people he had a part in killing in 1983 – concerns which echo those he expressed when he was previously in prison and his mental health deteriorated. X currently remains in Broadmoor where he says he feels safer. He is prescribed, and is taking, Clozapine (an anti-psychotic); his behavior is stable. Experts concur that it is extremely difficult to assess his level of dangerousness. X apparently still feels `at risk' to some degree from a real or imagined threat relating to his initial offence. It is also unclear to what extent his behavior on this occasion, as perhaps previously, has been consciously geared to a return to Broadmoor.