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HEALTH & SOCIAL CARE CONSULTING

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

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

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Ryan's family has asked that this statement from them, along with a photograph of Ryan is included in this report. It is important to draw the reader's attention to the fact that the photograph is of the victim, Ryan Merna, and not the perpetrator Mr P.

Statement from Ryan Merna's family

Up until August 14th 2016 our son Ryan was alive, living his life in the way he wished, harming no one else during the course of it, his family loved him and were only ever interested in seeing Ryan live his life as well as he could.

Ryan loved his drawing, had a passion for film, computer games and science fiction and was always working on writing and illustrating his own graphic novel.

Ryan loved his two sisters (who were then aged 27 and 11) selflessly, he was never demanding or asked to be treated differently. Ryan's younger sister often points out 'Star Wars' products remembering Ryan when doing so. Ryan introduced her to 'Studio Ghibli' films and they spent many weekends watching them together. Ryan also loved being with his grandparents and cousins, and enjoyed trips to the cinema with all his family.

Ryan was a good friend to those fortunate enough to enjoy his friendship always willing to give and share whenever he could.

Ryan was a strong, caring, kind, inoffensive young man who was always ready to give the help he felt was needed to those in a position of need, a young man who has left a positive mark on this earth and who will continue to live in the hearts of his family and close friends.

Ryan never asked for anything for himself but was generous and helpful to others. After a time in St Anne's he remained involved in supporting and inspiring those who were still under the care of their services, including Mr P giving him a bed to sleep in when one was not available through other means. He was polite to everyone, good humoured and intelligent.

Ryan's death has had a huge emotional impact on his family and friends, the manner of it compounding the grief felt for the untimely loss of a son, a brother and a friend.

The brutal nature of his unnecessary death enters two parents' thoughts on a daily basis, changing our whole outlook on life and presenting us with fears for our other children that simply did not exist prior to the 14th August 2016. Our whole demeanour and humour has been changed by the barbaric act perpetrated on Ryan. His death has brought previously unknown fears to his younger sister and has had a lasting effect on the physical health of his parents.

For Ryan's mother every day is different, some days she copes and on others she just wants to cry. She thought that whilst we would not get over losing Ryan, especially in the way it happened, we would deal with his loss, but it is still a constant struggle and sometimes it feels worse now than three and a half years ago. Each birthday, Christmas, family event is negotiated around but it is the events which catch us by surprise that are difficult to deal with, like looking in a cupboard and finding his photograph or seeing his favourite Studio Ghibli films on the television.

For Ryan's older sister, her brother's death has left a huge void in her life, a giant Ryan shaped hole where he once was. There is an empty space at the table, a silence when he would have spoken and no one to spoil the ending of a film we have just started to watch. Our life as we knew it imploded the day that he was brutally taken away from us and three and a half years on, the lasting devastating effects still permeate our lives on a daily basis.

Our youngest daughter is still having panic attacks, her last one was on Friday when all she wanted was to see Ryan, and unfortunately none of us can help her do that. Her happy place in her mind is playing Minecraft with Ryan with her duvet around her.

On August 14th 2016 Ryan died from 32 stab wounds at his flat, alone with no one coming to his aid despite his cries for help. We learnt of his death through social media. The perpetrator of this act was Mr P a man with a history of inflicting harm on others who was the subject of a Section 117 and who was under the care of the Dorset Forensic Team led by a Consultant Forensic Psychiatrist (referred to in this report as Dr B1).

Whilst clearing Ryan's flat I found a copy of minutes of a meeting concerning Mr P dated 11th July 2016 which shed the first rays of light on how what happened to Ryan might have come about. Mr P was described in these minutes as a 'loose cannon who is likely to have a psychotic episode'. We were not to know at this point in time that this discovery would lead to a whole new field of suffering when it came to dealing with Dorset Healthcare University NHS Foundation Trust.

We as parents recognise that the Trust and individuals in their employ did not murder Ryan, but we do recognise that Ryan's murder was preventable if the Dorset Forensic Team had given assertive, effective community treatment given the risk indicators surrounding him. The impact of Ryan's murder on his family is one thing we have had to deal with, the impact of the Trust's treatment of us thereafter is another altogether, and one which the Trust are entirely responsible for.

Up until our meeting with the former Chief Executive Officer of the Trust on the 21st March 2017 we received no unsolicited correspondence from the Trust, with the exception of an initial letter dated 31st August 2016 more than 2 weeks after Ryan's murder, and an email dated 31st January 2017 notifying me of the cancellation of a meeting with the former Medical Director.

We were not given at any stage the "appropriate engagement with the investigation process" promised in the key deliverables of the "Independent investigation into the care and treatment of Ryan Merna and Mr P" and I would quite happily refer to "a clear breakdown in communication" identified by the former Chief Executive Officer as deceitful behaviour at the very time we were most vulnerable and needed to know the truth and come to terms with our situation. The former Chief Executive Officer expressed a personal aim to ensure the truth was made public surrounding the Trust's involvement with Ryan and Mr P and a desire to be open with us in all matters going forward. Of course like so many of our dealings with the Trust this promise and desire were later proved to be false.

The Trust at various stages throughout our dealings with them have hidden behind patient confidentiality and data protection, even when they had no relevance and despite the guidance in the Serious Incident Framework Supporting Learning to Prevent Recurrence 2015. As a result of attending the trial of Mr P and the investigations carried out by Niche we know more about the Trust's involvement and recognise these were pathetic attempts at covering up deficiencies in the performance of individuals in the Trust and the Trust as an organisation.

The treatment we received from some of their most senior employees has at key times been one of disinterest, incompetence and insensitivity, leaving my wife and myself with more unnecessary hurt and distrustful of the Trust, but with more understanding of how things went badly wrong with the care and treatment of Mr P as the same traits were present within the Dorset Forensic Team.

Dr B1, just 4 days before Ryan's murder following a Care Programme Approach meeting confirmed Mr P to be "well in his mental state", whilst at the same time writing to Mr P's GP noting Mr P's current risk of suicide and current risk of harm to others to be "significant", and yet despite this view refused to admit Mr P to hospital on the 12th August 2016 despite his knowing that Mr P was homeless, non-compliant with his medication, using illicit drugs, drinking heavily, carrying a knife and hearing voices. Indeed when asked later about this non admission to hospital Dr B1 confirmed that the "threshold for admission had not in his view been reached".

Our trust in the ironically named Trust has been further shattered by the veracity of individuals at senior levels and within the Dorset Forensic Team. Dr B1's lack of awareness of Mr P's previous diagnosis of paranoid schizophrenia despite the fact he had written and signed two reports that Mr P had a history of psychotic symptoms or paranoid schizophrenia. A community mental health nurse's denial to investigators surrounding knowledge of Mr P's previous diagnosis of schizophrenia despite telling the court that he was aware of it. Dr B1's lack of awareness of the risk indicators presented by Mr P on the 12th August 2016 despite a social worker making it quite clear that "the team" which included Dr B1 were fully informed. The many inconsistencies in accounts given to by the team to different parties, accounts that differ from entries in Mr P's clinical records or do not appear at all.

Trust matters, all human relationships and dealings rely on trust, truth matters and it is important that everyone has access to the truth so that when things go wrong as they clearly did for Ryan, there can be learning from the mistakes and appropriate changes made. When we were at our most vulnerable we needed the truth, we needed the Trust to be open and honest and we needed them to keep us informed. I have referred to the above not necessarily to highlight wrong doing but to point out the distressing impact that the Trust's concealment had on us. The Trust has failed Ryan's family in its Duty of Candour piling hurt on hurt. It has not apologised to us and I do not doubt for one minute that it will pay a Barrister to do their best to withhold the truth at the impending inquest and protect the very people in its employment who really should be saying sorry to us, because they played a major role in Ryan's death.

We cannot have Ryan back with us, the staff involved needed to acknowledge their roles so that we could forgive and move on and hope that other's lives will not be similarly devastated.

The NHS is of course a wonderful organisation that we all need and should be lauded, but when it gets things wrong the effects can be catastrophic. At times like this the NHS has two choices, it can practice silence and 'cover up' hoping the truth will not be made known or it can be open and honest and produce something positive for those affected.

Written by Ryan's father

Contents

1 Executive Summary

1.1 NHS England, South commissioned Niche Health and Social Care Consulting (Niche) to carry out an independent investigation into the care and treatment of a mental health service user Mr P. Niche is a consultancy company specialising in patient safety investigations and reviews.

1.2 The independent investigation follows the NHS England Serious Incident Framework[1] (March 2015) and Department of Health guidance[2] on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services. The terms of reference for this investigation are given in full in Appendix A.

1.3 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services might be required which could help prevent similar incidents occurring.

1.4 The underlying aim is to identify common risks and opportunities to improve patient safety and make recommendations for organisational and system learning.

1.5 On 16 August 2016 Mr P killed Mr Ryan Merna by stabbing him multiple times.

1.6 We would like to express our condolences to Mr Merna's family. It is our sincere wish that this report does not add to their pain and distress and goes some way in addressing any outstanding issues and questions raised regarding the care and treatment of Mr P.

Mental health history

1.7 Mr P has an extensive mental health history with his first contact with services in May 1996. He then spent more than 13 years in various secure mental health hospitals before a first attempt at discharge to the community in September 2012.

1.8 Mr P was in the community under the care of Dorset HealthCare University NHS Foundation Trust (the Trust hereafter) for about six months before he was recalled to St Ann's Hospital (a secure mental health hospital) in March 2013.

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

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

1.9 He remained at St Ann's Hospital for a further eight months before being discharged into the community again in November 2013 on a Community Treatment Order.[3]

1.10 Mr P was cared for under a Community Treatment Order for about a year until November 2014. During this period, he received care and treatment from the Dorset Forensic Team and lived in supported accommodation. The Community Treatment Order was formally rescinded, after which care was provided on an 'informal' or voluntary basis.

1.11 In June 2015 Mr P moved to Cornwall to be close to his former partner and their son. At this time responsibility for his care and treatment was transferred to Cornwall Partnership NHS Foundation Trust. Mr P was initially under the care of the forensic team but after a brief period of transition he was transferred to a community mental health team. This transfer occurred because Mr P was not subject to a restriction order, or indeed to any part of the Mental Health Act. The forensic team in Cornwall was responsible for care coordinating only those patients who were subject to restriction orders and therefore responsibility for his care co-ordination did not sit with the Cornwall forensic team.

1.12 In Spring 2016 Mr P returned to Dorset. The move was not planned with the involvement of mental health services in either Cornwall or Dorset. Staff from the Dorset Forensic Team were first aware that Mr P had returned to Dorset after they received a telephone call from a member of staff at Mr P's previous supported accommodation provider to say that Mr P was sofa surfing there and had said he would not return to Cornwall. The Dorset Forensic Team accepted Mr P back onto their caseload almost immediately.

Relationship with the victim

1.13 Mr P and the victim Mr Merna were inpatients at the same time at Ravenswood House for seven weeks between 19 September and 9 November 2011, and at Twynham Ward, St Ann's Hospital, for five months between 27 March and 19 August 2013. There is no evidence that they formed any meaningful relationship. Indeed, the clinical records indicate that they were noted to have interacted on just two occasions, on 8 May 2014 and 29 June 2016.

1.14 It is unclear exactly when they made contact while they were living in the community, but it is believed that Mr P had been staying at Mr Merna's flat for some time because Mr P was homeless. Interviews undertaken as part of the Trust's investigation and our own investigation imply that Mr Merna may have had an undetermined relationship with a female who had also been in a relationship with Mr P. Indeed, this was confirmed in court by evidence given

[3] *Community Treatment Order is an order made by a responsible clinician to give a mental health patient supervised treatment in the community, under Section 17 A of the Mental Health Act 1983/2007) . It can be used if a patient has been detained in hospital under the Mental Health Act. Conditions are set aimed at helping the patient stay well, if the patient does not follow these then they can be brought back to hospital.*

by the said female. It should be noted that both of these matters came to light after Mr Merna's death.

Offence

1.15 On 16 August 2016 Mr Merna made a 999 call in which he reported that someone was coming at him with a knife and that he needed help. Police attended Mr Merna's flat and found him lying injured at the base of some communal stairs. Mr Merna had suffered multiple stab wounds from which he later died.

1.16 Mr P's trial heard that Mr Merna died as a result of sharp force injuries to his head, neck, chest, back trunk, and limbs. Mr Merna had sustained a total of 32 stab wounds.

Sentence

1.17 On 8 August 2017 Mr P was found guilty of manslaughter by reason of diminished responsibility (and acquitted of murder) after a 16-day trial at Winchester Crown Court.

1.18 Judge Keith Cutler said that Mr P was a "*very, very dangerous man*" and told the court that Mr P would be detained in a secure hospital for many years, "*possibly forever*".

1.19 On 13 November 2017 Mr P was sentenced to a hospital order under the provisions of Section 37 of the Mental Health Act, together with a restriction order without limit of time (Section 41 of the Mental Health Act).

Internal investigation

1.20 The Trust's internal investigation was conducted by an independent consultant forensic psychiatrist. The Trust chose to commission someone outside of the organisation because the incident was so serious and had resulted in the death of another patient.

1.21 The internal investigation reviewed the care and treatment provided to both Mr Merna and Mr P.

1.22 The report did not contain recommendations as such but did identify ten areas for improvement. The theme for each area for improvement was:

1. Impediments to the reappraisal of new admissions;
2. Forum for discussion about diagnostic issues;
3. Realistic process for managing homeless patients;
4. System for managing re-presentation of previous patients;
5. Lack of standard assessment of post-traumatic stress disorder symptoms within the admission process;

6. Lack of key performance indicators for consultants' assessment and review of patients;

7. Lack of key performance indicators for psychologists' assessment and provisional formulation on patients;

8. Lack of individualised crisis plan;

9. Absence of more sophisticated testing for illicit substances (eg spice and other synthetic agents);

10. Lack of access to expert primary care for patients in hospital.

1.23 The report also identified three suggestions for reflection. They were:

1. Dorset Forensic Team to reflect on the management of the risk factors presenting in 2016 and why the response in 2016 was different from the response to a lesser degree of disturbance in 2013.

2. Dorset Forensic Team (and the criminal justice liaison department and liaison services) to reflect on their own attitudes towards patients with personality disorder that impairs rather than allows access to mental health services. People, including people with personality disorder, do things for good reasons, and in [Mr P's] case, it could be argued that his understanding of his risks was better than the team's – trying (not necessarily very skilfully) to secure admission to hospital, or a safe environment, was actually a functional behaviour in terms of him managing his own risks.

3. The Dorset Forensic Team to reflect on their use of, and access to, information or out of area admission arrangements for forensic patients in crisis.

1.24 The internal investigation did not meet the standards set out in the NHS England Serious Incident Framework by not using root cause analysis and it was not written on the basis that it might become a public document because staff and patients were identified. One of the consequences of the failure to follow the NHS England Serious Incident Framework is that Mr Merna's family has not had sight of the full investigation report.

Independent investigation

1.25 This independent investigation has reviewed the internal process and has studied clinical information, interview transcripts and policies. The team has also interviewed staff who had been responsible for Mr P's care and treatment.

1.26 NHS England attempted to contact Mr P via his responsible clinician at the secure hospital where Mr P is detained. NHS England was initially told that Mr P had asked his clinical team to inform NHS England that he "*no longer need (sic) your service so he is not willing to meet up with you*". We

discussed this response with NHS England and expressed concern that it appeared that Mr P did not properly understand the purpose of the investigation. NHS England agreed and contacted Mr P's responsible clinician again but, despite following up the request, did not receive a response. Because of this, NHS England did not provide us with any contact details for us to make direct contact with Mr P's responsible clinician.

1.27 Neither of Mr P's parents are still living and we did not have contact information for any other family members.

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

1.29 We have also reviewed the communication between the Trust and Mr Merna's family and provide comment on the timeliness and appropriateness of those communications.

Conclusions

1.30 What we believe to be most important here is not specifically whether Mr P met the criteria for personality disorder, or psychosis, or both, but rather the processes by which clinical data relating to these diagnostic issues followed Mr P along his care pathway, and how it was available to and used by the clinicians involved in his care. The key reason why this 'data flow' is important is that diagnostic issues of this sort can affect how practitioners and services respond to patients and clinical scenarios, including when assessing and formulating risk and its management.

1.31 Given Mr P's history, and the recognised ongoing presence of known clinical risk factors, we conclude that his attendance at A&E on 4 June 2016 represented an opportunity for a formal, multi-disciplinary discussion about his management, possibly (but not necessarily) amounting to a formal Mental Health Act assessment.

1.32 We consider that the absence of a more detailed, complete and consistent diagnostic formulation regarding Mr P's by the forensic team in Dorset could have had a significant impact on the degree to which assessment and management of clinical risk was comprehensive and robust. It is clear from Trust records and our interviews with staff that the team in Dorset considered his presentation to entirely reflect personality traits (sometimes confounded by substance misuse). There is no evidence that staff reviewed (or were sufficiently aware of) how this diagnostic category had been previously exclusively ascribed (in 2009), closely following a period of several years during which a psychotic disorder had also been confidently diagnosed and treated. Similarly, there is no evidence that staff then considered whether Mr P's presentation (including adverse behaviours) might be linked to psychotic symptoms or relapse. While it is of course impossible to be certain in retrospect, we believe that service responses could have been different.

1.33 Regarding the way in which Mr P was accepted back onto the team's caseload without a multi-disciplinary review, we believe this was a further

missed opportunity for a formal discussion and recording of clinical perspectives, incorporating revising the available historical information and updating the diagnostic formulation. Had this taken place it would have ensured that any key decisions (whether different or not) would be more robustly informed and assured. The absence of a multi-disciplinary team review (as required by MAPPA Level 1) meant that the opportunity for the management plan to be more comprehensive and securely founded was impaired.

1.34 Finally, we also believe that had steps been taken by the clinical team to ensure they had a more comprehensive and detailed awareness of how the issues of presentation, diagnosis (especially around documented psychotic symptomatology) and treatment response had developed and been responded to by previous services, it is likely that they would have been able to develop a more nuanced and complex formulation of Mr P's presentation and behaviours. Following on from this, it is then at least possible that the processes of decision-making, and the events flowing from these, would have unfolded differently. For example, in comparable circumstances but where a differential or supplementary diagnosis of schizophrenia was not excluded, a team might be more likely to consider structured clinical examination and to the issue of whether a Mental Health Act assessment was clinically appropriate. In this, our conclusions are compatible with those of Dr Y's investigation, for example when she stated that "*I think that if the diagnosis of Schizophrenia had been explicit … services may have responded differently*".

1.35 We cannot say with certainty that decisions and outcomes would necessarily have been different, but in a service where important clinical information is not properly available, it is more likely that clinical decision making is less informed and less robust.

Predictability and preventability

1.36 Despite the level of concerns being expressed about the increase in Mr P's risks on Friday 12 August 2016, it is our view that the clinical team treating Mr P could not have predicted that he would kill Mr Merna that weekend.

1.37 In general, if patients with significant and clinically relevant risk profiles (including complex presentations, serious history of violence, deteriorating mental state or risk of relapse) are not appropriately admitted to hospital within a reasonable timeframe, there will overall be an increased likelihood of serious incidents. In individual cases, attempting to establish what would have happened following different actions is fraught with difficulty. In particular, it is impossible to retrospectively definitively state, based on what clinicians knew, or should reasonably have known, at the time, what alternative series of interventions would have followed. We are not concluding that Mr P's presentation and mental state was such that he should certainly have been detained in hospital. What remains unknown is the possible impact of a different, more comprehensive diagnostic formulation on the relevant decision makers at the time. In particular, had staff appreciated or recognised that previous forensic clinicians had diagnosed and treated,

schizophrenia (in addition to personality disorder), clinical assessment and examination may have been influenced.

1.38 We note that Dr Y has previously concluded, in the context of Mr P's return to Dorset, that "*A full review might have led to a more serious consideration being given to readmission to hospital, especially if the diagnosis had been revised*". She also comments on Mr P's presentation (and non-assessment) on 4 June 2016 "*… a fresh assessor might have elicited signs of mental illness purely by the process of structured mental state inquiry*". Finally, she also suggested that in the period prior to the homicide, "*if the diagnosis of Schizophrenia had been recognised, this would have influenced the decision about the need for a hospital admission*". While accepting that this must be speculative in nature, we agree that in the context of a more comprehensive formulation, it is possible that decision making around hospital admission, including formal detention, might have been materially influenced.

1.39 It is documented that there were concerns:

- about a decline in Mr P's mental and physical state;
- that his compliance with prescribed medication was doubted;
- that he was consistently expressing significant frustration;
- that he was without stable accommodation.

1.40 He had alluded to thoughts about self-harm or offending if the accommodation issue was not resolved. These factors had previously been recognised as relevant to risk, and at the time it was acknowledged that the level of risk was increasing. As we have suggested above, if there was a different clinical perspective around a presentation or situation such as this, there might well have been grounds to formally consider whether a Mental Health Act assessment should have been undertaken.

Recommendations

1.41 This independent investigation has made recommendations for the Trust, the NHS Dorset Clinical Commissioning Group, agencies involved in managing individuals through MAPPA and NHS England to address in order to further improve learning from this event.

1.42 The recommendations have been given one of two levels of priority:

- **Priority One:** the recommendation is considered fundamental in that it addresses issues that are essential to achieve key systems or process objectives and without which, the delivery of safe and effective clinical care would, in our view, be compromised.

- **Priority Two:** the recommendation is considered important in that it addresses issues that affect the ability to fully achieve all systems or process objectives. The area of concern does not compromise the safety of patients but identifies important improvement in the delivery of care required.

Priority One

Recommendation 1

The Trust must ensure that all serious incident reports comply with all of the standards set out in the NHS England Serious Incident Framework so that:

- root causes to incidents are clear in cases where they are identified;
- appropriate learning can be identified and shared;
- findings can be shared in an open and transparent way with affected parties.

Recommendation 2

The NHS Dorset Clinical Commissioning Group must ensure that provider serious incident reports comply with all of the standards set out in the NHS England Serious Incident Framework, that there is an audit trail of assessment of serious incident reports, and that appropriate action is taken when this is not the case.

Recommendation 5

The Trust must ensure that the forensic team is clear about all current and previous diagnostic formulations, particularly where there have been substantial periods of care in multiple settings, in order to ensure that assessment and treatment plans are relevant and appropriate.

Recommendation 7

Agencies involved in managing individuals through the MAPPA process must ensure that information about risks and management of those risks is passed to other areas when an individual moves to the jurisdiction of another MAPPA group. The Trusts involved in this case must review their existing MAPPA policies with this recommendation and associated findings in mind.

Recommendation 8

NHS England must ensure that secure services provide all relevant clinical information within progress reports, correspondence and discharge documents so that future clinical teams have a complete picture of a patient's diagnosis, risk and treatment history.

Recommendation 9

The Trust must also ensure that HCR-20's (risk assessments) are kept up to date with relevant information, particularly when responsibility for the patient's care and treatment is being transferred from another provider.

Recommendation 10

The Trust must ensure that all communications executing their Duty of Candour responsibilities (including when acting in the spirit of Regulation 20) fulfils all of the requirements of the Regulation.

Recommendation 11

Cornwall Partnership NHS Foundation Trust must ensure that when a patient is discharged to the care of an originating team a full summary of the patient's care and treatment whilst in Cornwall is provided to the receiving team.

Priority Two

Recommendation 3

The NHS Dorset Clinical Commissioning Group must ensure that:

- provider action plans properly address recommendations in the associated serious incident reports;
- provider action plans are appropriately monitored, and that evidence is assessed to provide assurance that the required actions are in place;
- when actions are not completed within the agreed timeframe, the provider is required to explain the delay.

Recommendation 4

The Trust must ensure that patients are provided with appropriate information about medicines in order for them to be able to make an informed decision about consenting to accept the medicine. This is even more important when a medicine is prescribed off licence.

Recommendation 6

The Trust and its commissioners must ensure that the relevance of previous post-traumatic stress disorder diagnoses and of potential current post-traumatic stress disorder symptoms should be routinely considered, and appropriate guidance followed where relevant.

2 Independent investigation

Approach to the investigation

2.1 The independent investigation follows the NHS England Serious Incident Framework[4] (March 2015) and Department of Health guidance[5] on Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services. The terms of reference for this investigation are given in full in Appendix A.

2.2 The main purpose of an independent investigation is to ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. The investigation process may also identify areas where improvements to services are required which could help prevent similar incidents occurring.

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

2.4 The investigation was carried out by Ms Naomi Ibbs, Senior Consultant for Niche, with expert advice provided by Dr John McKenna, retired Forensic Consultant Psychiatrist. Family support and advice was provided by Mr Christopher Gill, Senior Consultant for Niche.

2.5 The investigation team will be referred to in the first-person plural in the report.

2.6 The report was peer reviewed by Dr Carol Rooney, Deputy Director, Niche.

2.7 The investigation comprised a review of documents and interviews, with reference to the National Patient Safety Agency (NPSA) guidance.[6]

2.8 NHS England contacted Mr P at the start of the investigation, explained the purpose of the investigation and sought his consent to access to relevant records. Although Mr P provided his consent to for us to access his records, he did not wish to meet with us or NHS England.

2.9 Whilst it is usual for an investigation of this nature to focus on a specific period of time, this is most commonly a few months or years prior to the incident. In Mr P's case NHS England asked us to review Mr P's care and treatment for the 20 years prior to the homicide, from before he was first admitted to a

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

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

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

secure mental health hospital. For this reason, the report is significantly longer than most reports of this nature.

2.10 We used information from Dorset HealthCare University NHS Foundation Trust (the Trust hereafter), West London Mental Health Trust, Southern Health NHS Foundation Trust, Cornwall Partnership NHS Foundation Trust, and Mr P's GP surgery to complete this investigation.

2.11 As part of our investigation we interviewed:

- Care coordinator, Cornwall community forensic service;
- Community mental health nurse (formerly in the forensic team);
- Consultant clinical forensic psychologist;
- Consultant forensic psychiatrist (mainly responsible for Mr P's inpatient care and treatment);
- Consultant forensic psychiatrist (mainly responsible for Mr P's community care and treatment);
- Consultant forensic psychiatrist, Cornwall community forensic service;
- Deputy Director of Safety, Improvement and Effectiveness;
- Independent investigator who completed the internal report;
- Medical Director;
- Non-Executive Director and Chair of the Quality Governance Committee;
- Senior social worker (formerly);
- Social worker (forensic services).

2.12 All interviews were digitally recorded, and interviewees were subsequently provided with a transcript of their interview. Interviewees were invited to review the transcript and to "*add or amend it as necessary, then sign it to signify that you agree to its accuracy and return it to Niche*". Interviewees were further advised that if we did not receive the signed transcript within two weeks, we would assume that the interviewee accepted the contents as accurate. We interviewed 12 individuals and ten transcripts were returned to us.

2.13 A full list of all documents we referenced is at Appendix B, and an anonymised list of all professionals is at Appendix C.

2.14 The draft report was shared with:

- NHS England;

- the Trust;
- the author of the internal investigation report;
- West London Mental Health Trust;
- Southern Health NHS Foundation Trust;
- Cornwall Partnership NHS Foundation Trust;
- the GP surgery;
- Dorset Clinical Commissioning Group.

2.15 This provided opportunity for those organisations that had contributed significant pieces of information, and those whom we interviewed, to review and comment upon the content.

Contact with the victim's family

2.16 Contact for the victim's family was with Mr Merna's mother and father. We met with them at the start of the investigation to explain the investigation process and invited them to contribute to the terms of reference. We met with them again part way through the investigation to provide them with an update and offered additional telephone updates.

2.17 Mr Merna expressed his dissatisfaction with the Trust in respect of the way in which he felt members of staff had not been open and honest with him and his wife. Mr Merna described frustration that the family had not seen a copy of the internal investigation report relating to Mr P's care and treatment.

2.18 We offered Mr Merna support in writing an impact statement, but this offer has not been taken up.

2.19 We met with Mr Merna's family after we had completed our report and at their request we have included a copy of a statement from them at the beginning of this report.

Contact with the perpetrator's family

2.20 NHS England did not provide us with contact details for Mr P's former partner or their son. Mr P's parents had both passed away some time ago. We therefore had no contact with Mr P's family.

Contact with the perpetrator

2.21 NHS England attempted to contact Mr P via his responsible clinician at the secure hospital where Mr P is detained. NHS England was initially told that Mr P had asked his clinical team to inform NHS England that he "*no longer need [sic] your service so he is not willing to meet up with you*".

2.22 We discussed this response with NHS England and expressed our concern that it appeared that Mr P did not properly understand the purpose of the investigation. NHS England shared this concern and contacted Mr P's responsible clinician again but, despite following up the request, did not receive a response. Because of this, NHS England did not provide us with any contact details for us to make direct contact with Mr P's responsible clinician.

2.23 NHS England offered Mr P the opportunity to meet with us prior to publication of the report. Mr P accepted this offer and we met with him, along with NHS England after he had spent many sessions with secure hospital staff supporting him to read the report. Mr P did not have any questions and confirmed he was happy with the level of personal detail in the report, knowing it would be published.

Structure of the report

2.24 Section 3 provides detail about Mr P's background; Section 4 sets out Mr P's notable physical health care and treatment; and Section 5 sets out the details of the mental health care and treatment provided to Mr P.

2.25 We have included an anonymised summary of those staff involved in Mr P's care for ease of reference for the reader. These can be found at Appendix C.

2.26 Section 6 considers the Trust response under Duty of Candour and examines the communication the Trust had with Mr P and his family and Mr Merna's family.

2.27 Section 7 provides a review of the Trust's internal investigation and reports on the progress made in addressing the organisational and operational matters identified.

2.28 Section 8 examines the issues arising from the care and treatment provided to Mr P and includes comment and analysis.

2.29 Section 9 sets out our overall conclusions and recommendations.

3 Background of Mr P

Childhood and family background

3.1 Mr P was born and brought up in the Taunton area of Somerset. Reports indicate that he had an unremarkable early development.

3.2 Mr P's father had previously been married and had a daughter from that marriage. Mr P's father met Mr P's mother in around 1955.

3.3 Mr P was the fifth of seven children born to his parents. Reports indicate that Mr P had poor relationships with his six siblings; in 2014 it was reported that he had some telephone contact with one, and no contact at all with the other five siblings.

3.4 His father reportedly had a history of violence, including long-term imprisonment for assault, and he was repeatedly physically violent, neglectful, cruel and fear-inducing to Mr P from when he was about seven years old. Mr P told clinical staff that the abuse from his father stopped when he threatened to slit his father's throat. Mr P would have been about 14 years old at this time.

3.5 Mr P told staff that his mother had been unwell with heart disease for as long as he could remember. Reports indicate that she died in November 1993 aged 57 following diagnosis with a life limiting illness earlier that year.

3.6 Mr P had contact with a child guidance clinic when he was aged eight or nine years old. This intervention was prompted by school phobia stealing money at school and enuresis (involuntary urination). We recognise that this is very sensitive and personal information however, we consider it to be relevant because Mr P continued to suffer from enuresis when he was an adult and it can be an indicator of childhood abuse.

3.7 A later report stated that Mr P had "*confessed to setting fire to his school aged six*" and a music therapy session note from 16 February 2001 referred to Mr P setting several fires at school over a period of years. It is also reported that Mr P twice stole money by setting up fraudulent charity activities.

3.8 In February 2012, Mr P's father reported that his son had been "*verbally threatening and physically violent throughout his childhood and early adulthood … had no respect for his family or any type of authority … constantly fighting with others … believed he could get away with anything*".

3.9 In 2002, Mr P disclosed to clinical staff that when aged 12 or 13 years, he had been sexually assaulted (raped) by a local male, described as a friend of his father. Clinical teams recorded that the "*anniversary*" of this event was 12 April.

3.10 Mr P also reported that for about three years from aged 14 years, he had a "*relationship*" with a woman in her thirties. Mr P said that she was the mother of an ex-girlfriend.

3.11 Mr P had numerous difficulties at school with his behaviour, these included swearing, fighting, stealing, truancy, and property damage. It culminated in him being expelled from school aged 15 years after he had assaulted a teacher.

3.12 Mr P reported to clinical staff repeated episodes of animal cruelty during his childhood. He also reported committing six stabbings in addition to the two for which he has been convicted.

3.13 Mr P has an extensive history of misuse of multiple substances from aged 13 years. This includes solvents (which he continued to use until 1995), cannabis, amphetamine, and cocaine in 1998 (he claimed he had spent over £30,000 on this drug). Other substances that he used less often were ketamine and LSD.

3.14 Mr P had also used alcohol heavily and at times was physically dependent. He reported withdrawal symptoms aged 16 years.

Training and employment

3.15 Mr P left school with no qualifications but could read and write and do basic maths. He obtained a city and guilds qualification whilst in custody.

Relationships

3.16 Mr P has had two significant relationships that resulted in children.

3.17 In around 1984 Mr P started a relationship with Miss Z1. Mr P reported that he used drugs and alcohol throughout their relationship and that in September 1986 Miss Z1 gave birth to their son Mr Z2.

3.18 During their relationship Mr P spent time in prison and when he was in the community he lived with Miss Z1 and her parents.

3.19 After the relationship with Miss Z1 ended, Mr P reverted to heavy use of drugs such as cocaine, amphetamine, and MDMA.

3.20 A report from July 1993 refers to Mr P having a partner Miss Z3, who already had children. Mr P described this as his second serious relationship. It appears that Mr P did not live with Miss Z3 because reports indicate that he lived with his parents and three brothers when he was released from prison on parole in August 1993.

3.21 A report from February 1995 indicates that Mr P's relationship with Miss Z3 had ended. Another report from July 1995 indicates that Mr P was in a relationship with another female, Miss Z4, who had given birth to a son (Mr Z5). However, Mr P told clinical staff that he did not see Mr Z5 after he was about eight months old.

3.22 A report from 1988 indicates Mr P told staff that in his late teens he had been married briefly to one person, Miss Z9, but another report suggests that he had been married to Miss Z3.

Forensic history

3.23 Mr P has an extensive forensic history, with the first incident noted in December 1983 when he was about 17 years old. Table 1 below provides a summary of those offences and the nature of the punishment.

Table 1 - Summary of Mr P's offences to March 2001

Date	Offence	Outcome
December 1983	Actual bodily harm	Unclear
February 1984	Section 18 wounding	Three years youth custody
January 1985	Theft from vehicle x2 Deception Taking without consent	Unclear
June 1986	Taking without consent Driving whilst disqualified	Unclear
October 1986	Criminal damage Breach of binding over	Six months' youth custody
December 1987	Taking without consent Arson Theft Driving whilst disqualified Driving without insurance	Unclear
May 1989	Criminal damage Burglary Theft	12 months' imprisonment
April 1992	Section 20 wounding Theft Deception	Three years' imprisonment
June 1995	Actual bodily harm Arson Resisting arrest	Five months' imprisonment
July 1996	Possession of a firearm Possession of a firearm whilst prohibited	18 months' imprisonment
August 1998	Threats to kill x2	30 months' imprisonment
March 2001	Theft	Cautioned

3.24 Given that we have reviewed such a long period of time in Mr P's care and treatment we have provided an overview in Table 2 of where Mr P was during that period of time.

Table 2 - Overview of Mr P's location between 1996 and 2016

Dates	Location/event	Period of time
May 1996	First contact with mental health services	n/a
July 1996 to May 1997	Custody	Ten months
May to October 1997	Community	Five months
October to December 1997	Second and third admissions to St Ann's Hospital	Two months
11-13 February 1998	Index offences	Two days
February 1998 to April 1999	Custody	14 months
April 1999 to December 2002	Ravenswood House admission	Three years eight months
December 2002 to March 2009	Broadmoor admission	Six years three months
March 2009 to November 2011	Ravenswood House admission	Two years eight months
November 2011 to September 2012	St Ann's Hospital admission (fourth occasion)	Ten months
September 2012 to March 2013	First discharge on Community Treatment Order	Six months
March 2013 to November 2013	St Ann's Hospital admission (fifth occasion)	Eight months
November 2013 to November 2014	Second discharge on Community Treatment Order	12 months
November 2014 to June 2015	Community - end of statutory supervision	Eight months
June 2015 to April 2016	Community – in Cornwall	Ten months
April to August 2016	Community – in Dorset	Four months

3.25 Mr P became an adult in October 1984. Between then and 1996, a period of 12 years, he spent nearly four years in either youth custody or prison (either on remand or as a sentenced prisoner).

3.26 From 1996 to 2016 Mr P, a period of 20 years, Mr P spent more than 16 years in hospital (either as a detained or informal patient) or in prison.

3.27 At the time of the offence, aged nearly 50 years, Mr P had spent less than a third of his adult life living freely in the community.

4 Notable physical health care and treatment

4.1 In 1990 Mr P was taken to an emergency department via ambulance. He presented as "*very drunk*" and had broken the window of an ambulance by headbutting it.

4.2 Tests showed an abnormal electroencephalogram (EEG)[7] and he was prescribed carbamazepine[8] for possible epilepsy. Mr P had several admissions to a general hospital with possible seizures and it appears that later he reported that he had fabricated some of the seizures.

4.3 On 10 August 1990 he was admitted to hospital following an overdose of co-proxamol.[9]

4.4 On 22 August 1990 Mr P was admitted to hospital unconscious, following reports of a headache. An EEG was reported as being normal with "*slight excess of diffuse slow cerebral activity*" and his computerised tomography (CT)[10] scan was normal. He was prescribed carbamazepine again.

4.5 In September a consultant neurologist queried complex partial seizures. Within four days Mr P was admitted after an apparent seizure. Two weeks later Mr P was again admitted in an agitated state and thought to have had convulsions. However, "*doubt was expressed in his notes as to whether he was actually conscious*". Mr P was discharged from hospital into police custody, but it is unclear for what offence.

4.6 In October Mr P was readmitted after more apparent seizures and later reported overdosing on carbamazepine.

4.7 Again, in November Mr P was admitted after an apparent seizure. Records note "*after breaking a portable lamp he had a further 'attack' which was clearly not a fit … further attacks in hospital in which he was 'thrashing about' were thought not to be epileptic. When confronted by the possibility that these might be 'manipulative' attacks, he took his own discharge*".

4.8 In December Mr P's GP referred him to a consultant physician in Taunton noting "*grand mal epilepsy … has been witnessed by three separate GPs and we are convinced that he is unable to feign this … on one occasion he became deeply cyanotic … He fell out with [a doctor's] team when they accused him of malingering … Since [Nov 1988 assault] his family had*

[7] *An EEG is a recording of brain activity.*

[8] *Carbamazepine is an anticonvulsant or anti-epileptic drug that is used to prevent and control seizures. The medication works by reducing the spread of seizure activity in the brain and restoring the normal balance of nerve activity.*

[9] *Co-praxamol is a combination of two active ingredients, paracetamol and dextropropoxyphene. It is used to treat mild to moderate pain when other painkillers have proved ineffective or are inappropriate.*

[10] *A CT scan uses x-rays and a computer to create detailed images of the inside of the body. CT scans are sometimes also referred to as CAT scans.*

noticed a change in his personality and behaviour in that he had become more aggressive …".

4.9 Whilst awaiting trial (it is unclear for what offence) Mr P was admitted after an overdose of carbamazepine and alcohol. It was reported this was one of many overdoses since he had been awaiting trial.

5 Mental health care and treatment

1996 – first contact with mental health services

5.1 By January 1996 Mr P was living in and registered with a GP in Weymouth.

5.2 In May, aged 29 years, Mr P had his first contact with mental health services. He had been arrested after swallowing a razor and smashing the windows in a local fire station. He had taken amphetamine and was paranoid, frightened for his life, hallucinating and suicidal. There are also several potential psychotic symptoms including believing that someone was going to shoot him, and auditory and visual hallucinations. Mr P was admitted to the Forston Clinic the same day and the initial differential diagnosis was amphetamine psychosis or psychotic depression. However, by the time Mr P was discharged his diagnosis was mixed personality disorder and substance misuse. Whilst he was in hospital Mr P continued to take illicit drugs and alcohol and was prescribed significant amounts of antipsychotic medication including haloperidol 20mg daily. A urine drug screen conducted on 16 May was positive for cannabis. Mr P appeared to think he needed to hit someone to be sectioned and receive proper treatment. However, on 20 May he was discharged with no medication and with a diagnosis of "*personality disorder, mixed type*".

5.3 In July Mr P was arrested for possession of a firearm and later remanded in custody. It appears that he had taken a gun out in public and may have been seeking a partner or ex-partner. One report states, on 24 July, after consuming alcohol and chlormethiazole,[11] Mr P was refused entry to a pub and returned with a pump action shotgun. A former partner was apparently in the pub. There were concerns that he had been seeking his girlfriend, and it is recorded that the shotgun had not been recovered.

5.4 Mr P told a probation officer in November that year that he had strong feelings of paranoia and felt completely out of control. He reported that he was holding a shotgun for someone to whom he owed a drug-related favour.

5.5 Assessments by two psychiatrists did not conclude that Mr P was psychotic. He said he had never befriended or trusted anyone and had had lifelong difficulties relating to anyone. Mr P reported that he bore grudges and described deep-seated hatred for the man he believed took his second girlfriend away from him, saying he would show him no mercy if they met. He said he had taken benzodiazepines and alcohol, had decided to dispose of the shotgun, and had not realised it was visible while he walked round the streets. At that time Mr P was taking carbamazepine and lofepramine.[12]

[11] *Chlormethiazole is a sedative and hypnotic drug used in treating and preventing symptoms of acute alcohol withdrawal. It is highly toxic and If taken with alcohol can be potentially fatal.*

[12] *Lofepramine is a tricyclic antidepressant that is used to treat depression.*

5.6 Mr P has since reported to clinical staff that he was involved in a "*major drugs racket*" and that he carried a gun for protection.

1997 – community and St Ann's Hospital

5.7 In January, following his conviction for firearms offences Mr P was sentenced to 18 months' imprisonment.

5.8 In March the probation service made a referral to the local forensic service because Mr P had cut his neck whilst in prison. When the local forensic service discussed Mr P at a meeting on 25 April, professionals regarded him as high risk and stated that no visits would be undertaken at Mr P's home address and that staff must not assess him alone. The meeting noted Mr P "*has learnt how to control situations with threats of violence … there is nothing that psychiatric services can offer …at present*".

5.9 On 7 May Dr N3, consultant psychiatrist, wrote to all other consultants indicating that Mr P had a diagnosis of personality disorder, that he was a "sociopath" and that Dr N3 would not be prepared to accept consultant responsibility. Dr N3 further indicated that Mr P had no treatable mental illness and that "*admission would be entirely inappropriate … He must not be assessed under any circumstances whatsoever by a single person*".

5.10 By 13 May Mr P had been released from custody and appeared to have moved to the Bournemouth area. It is reported that he lived in a therapeutic community run by monks (Cerne Abbas Priory) and that after committing criminal damage to the priory whilst drunk, he was placed in a probation hostel. It is again noted that Dr N3 had regarded Mr P as having an untreatable personality disorder and had refused to re-admit him to Forston Clinic.

5.11 In August Mr P was assessed by the Dorset Community Forensic Team. At this time the prescription of carbamazepine had been discontinued and Mr P reported uncontrollable rage after drinking. Mr P was offered a trial of individual and group therapy.

5.12 The following month Mr P moved to Dorset Lodge in Bournemouth, a hotel for former prisoners with mental health problems.

5.13 In early October Mr P was admitted to St Ann's Hospital in Poole. It was reported that he was using amphetamine and hearing whispering sounds. He discharged himself when staff made it clear that amphetamines should not be prescribed. Staff noted:

> *"finds it very difficult to trust anybody … is unable to relate to anybody …"*

"demanding substances …would like dexedrine[13] …serious suicidal risk …multiple scars bilaterally to neck …claims to hear voices, whispering, from behind him…"

5.14 In early December Mr P was admitted to St Ann's Hospital under Section 2 of the Mental Health Act (1983) after taking an overdose. Mr P reported that his best friend had gone off with his girlfriend, and that he felt an uncontrollable rage when drinking alcohol and heard whispering voices that encouraged him to be violent. Mr P was prescribed various antipsychotic, anxiolytic and antidepressant drugs including chlordiazepoxide,[14] chlorpromazine,[15] lofepramine and sertraline.[16] Staff noted Mr P was "*totally uncooperative with the on-call doctor … The morning after … he was relatively co-operative but still slightly menacing … very poor eye contact, monotonous speech … did claim to hear voices when on drugs … his claimed compliance with lofepramine."* Mr P was discharged after two days, with diagnoses of mild depression, anxiety and amphetamine dependence but remained under the care of the forensic community mental health team.

1998 – community and prison

5.15 In January 1998 Mr P had been referred to the community drugs team and had completed some individual and group work. It was reported that he was using amphetamines weekly.

5.16 On 11 February Mr P was seen at an outpatient clinic when he was prescribed sertraline 50mg and chlordiazepoxide 60mg.

5.17 Between 11 and 13 February Mr P committed a number of offences whilst he was living at Dorset Lodge. Mr P was preoccupied with and spoke increasingly about violence and made specific threats of serious harm to specific male residents and to his ex-partner's partner. One report stated that Mr P threatened to attack him with one of two secreted shotguns. Mr P was persuaded to attend St Ann's Hospital for assessment, where he initially refused then accepted an informal admission, before aggressively demanding medication and leaving the ward.

5.18 Mr P said that he would use serious violence if any male made a threat towards him or if he perceived such a threat. Mr P reported that he was frightened of going out because of what he would do to someone under

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[13] Dexedrine is a trade name for a version (isomer) of amphetamine, and hence is often used or sought by drug users, especially amphetamine users.

[14] Chlordiazepoxide is commonly used to treat mental disorders including anxiety and panic attacks. Chlordiazepoxide is a generic name for this drug, it is sold under a number of different brand names including Librium, Poxi, Libritabs and Mitran.

[15] Chlorpromazine is a medication used to treat mental disorders such as schizophrenia or psychotic disorders and severe behavioural problems in children. It helps patients to think more clearly, feel less nervous and take part in everyday life. It can reduce aggressive behaviours and the desire to hurt oneself or others.

[16] Sertraline is an antidepressant in a group of drugs called selective serotonin reuptake inhibitors (SSRIs). Sertraline affects chemicals in the brain that may be unbalanced in people with depression, panic, anxiety, or obsessive-compulsive symptoms.

certain circumstances. He spoke of removing a resident's eye with a smashed light bulb, and of slicing open the resident's abdomen.

5.19 Dr R3, consultant psychiatrist, later stated (after seeing him in Sep 1998) that admission had been agreed "*because he was homeless, and the purpose of this brief admission was to provide a roof over his head until some other accommodation could be found*".

5.20 A member of staff at Dorset Lodge said Mr P was "*top dog … other residents were wary of [him] … he strutted around the home as though he was in charge …he continually mentioned violence, what he had done in the past …*"

5.21 After Mr P left St Ann's Hospital it appears that staff put him in a taxi back to Dorset Lodge where police were waiting for him. Dorset Lodge staff had locked him out because he had already been evicted but when Mr P was unable to get into Dorset Lodge he ran off towards Bournemouth.

5.22 The police clearly were able to locate and detain Mr P because on 16 February he was remanded by a Magistrates Court for medical examination.

5.23 Between February and September Mr P was seen by three psychiatrists and one psychologist. To each of them Mr P reported potentially psychotic symptoms, and sometimes also graphic violent thoughts, including voices telling him to kill himself and others, voices telling him to harm others in specific and graphic ways, visual hallucinations, he believed that people were after him, and he also reported the voice of "*Hans Blood*"[17] telling him to kill people and eat their brains. He also spoke of frequent sadistic fantasies of hurting other people.

5.24 The psychology report suggested that he may have "*schizophrenic tendencies*", however the majority opinion was that the diagnosis was personality disorder with substance misuse. Mr P reported that he was very sensitive to people ridiculing him and that he reacted violently to it. He was regarded by those who assessed him as highly impulsive, and dangerous.

5.25 In custody, Mr P received significant doses of antipsychotic medication (including depot injections),[18] was not allowed to associate with peers because of reported urges to harm others, and he was located in the healthcare wing because of suicidal thoughts. Mr P reported that he was hearing the voice of "*Hans Blood*", telling him to kill people and eat their brains. He also reported that he believed people were talking about him.

5.26 In June Mr P told clinical staff that be believed his court case would be thrown out. He was derogatory about hostel staff and stated that he felt staff on the hospital wing of the prison did not like him. In addition, Mr P thought people were talking about him. He reported that he used violence to solve things, and drugs to calm down. He said that he had never had any close friends and

[17] *"Hans Blood" is the name that Mr P gave to the voice that told him to do bad things. It is also sometimes referred to as "Hawksblood", but we have always used the term "Hans Blood".*

[18] *Depot injections are long acting preparations of antipsychotic medication*

did not trust other people, and that "*I need help. I'd like to be medicalled (sic) to a hospital".*

5.27 At the end of July Mr P chose to plead guilty in advance of his trial.

5.28 In early August he moved from HMP Dorchester to HMP Winchester due to management difficulties (a later unrelated document states that he had cut his throat). Mr P complained of voices in his head, self-injury, suicidality and violent thoughts. A member of staff recorded "*He had thoughts about what it would be like to kill someone".* He was diagnosed with mixed personality disorder.

5.29 On 20 August Mr P was convicted of two counts of threats to kill.

5.30 On 25 August Mr P was being managed in the health care wing due to his stated suicidal intent and voices telling him to harm others. Staff here noted "*long-term personality disorder*".

5.31 At the end of September, a consultant psychiatrist wrote that admission to secure hospital would be of no benefit to Mr P and a few days later Mr P was sentenced to 30 months' imprisonment, at Bournemouth Crown Court, with no hospital disposal having been recommended.

1999 – prison and Ravenswood House

5.32 On 15 January Mr P described a habitual pattern of cutting himself as an attempt to gain relief from his feelings of tension.

5.33 On 25 March Mr P was assessed for a transfer from prison to hospital under Section 47 of the Mental Health Act (1983).[19] The reports noted that Mr P was at high risk of re-offending and that his diagnoses were "*mixed personality disorder with borderline and antisocial features*". Dr J2, consultant psychiatrist, also noted "*conduct disorder in childhood … antisocial behaviours … fantasies of sadistic infliction of pain … emotional instability, uncertainty about identity, low self-esteem, chronic feelings of loneliness and abandonment …*" and "*he has been very demanding of staff in regard to medication…*".

5.34 On 1 April a warrant under Section 47 of the Mental Health Act was issued for Mr P's transfer to secure hospital. The warrant specified the legal category of "*psychopathic disorder*". Mr P was transferred from HMP Winchester to a medium secure unit, Ravenswood House in Fareham, on 6 April. His consultant psychiatrist at this time was Dr M1.

5.35 During May it was recorded that Mr P was "*very menacing to the staff and patients*" and that when Mr P was in prison, if staff refused his request for medication he would destroy property so that he would be taken to a strip cell and injected. Mr P told staff "*My anger and hostility would get me what I*

[19] *Section 47 of the Mental Health Act allows a sentenced prisoner to be transferred to hospital for assessment and treatment.*

want". Mr P also spoke openly about thoughts of extreme violence towards his ex-partner's new partner (Mr Z6).

5.36 A case conference held on 19 May noted that Mr P experienced frequent voices telling him to harm others, violent fantasies, and that he had made direct threats to staff and residents at Dorset Lodge. Mr P *"frequently*" stated he had secreted a gun (presumably in the community) and would retrieve it at the first opportunity. Mr P reported auditory hallucinations of "*Hans Blood*", commanding him to hurt others and himself. He felt that other people were talking about him behind his back. Staff planned interventions for post-traumatic stress disorder but his primary diagnosis was personality disorder (dissocial with paranoid traits) and he was prescribed depot flupentixol decanoate[20] 40 mg fortnightly plus carbamazepine as a mood stabiliser.

5.37 On 26 May staff noted that Mr P "*believes people are reading what he is thinking … mentioned strange thoughts of wanting to kill fellow patient… I have no reason and I don't understand why because he is supposed to be my friend …"*

5.38 On 1 June carbamazepine was stopped and on 15 June Mr P's sentence expired (although he remained in hospital on a 'Notional' Section 37 of the Mental Health Act (1983) until 29 January 2000). Mr P reported having been physically abused and raped as a child and was noted to have post-traumatic stress disorder. He continued to express thoughts of graphic violence, and remained fixed on harming the man who had run off with his ex-partner. Mr P said that he had previously feigned physical illness, and that he continued to experience auditory hallucinations telling him to harm himself and others. He stated that he had no quibbles about hurting other people, he felt nothing and had no conscience. To Mr P thoughts of violence were exciting.

5.39 At the end of June staff noted that they felt that Mr P's voices did "*not really have a schizophrenic element*".

5.40 In mid-July Mr P cut the back of his neck with a razor. His responsible medical officer (now known as a responsible clinician) at this time was Dr B4, a specialist registrar in forensic psychiatry.

5.41 During August Mr P's leave was stopped after he was thought to be supplying his hypnotic medication to another patient. This behaviour seemed to continue into September.

5.42 At a case conference on 8 September it was noted that Mr P continued to have "*alien thoughts*"[21] telling him to torture other people, with associated images, and the voice of "*Hans Blood*". Mr P was also suffering from night time incontinence (urine). It is of note that he was ringing his father daily at

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[20] Flupenthixol (also known as flupentixol) is used in the treatment of schizophrenia. It is thought to work by affecting nerve pathways in certain areas of the brain to help correct chemical imbalances that cause the symptoms of schizophrenia.

[21] We believe that the word 'alien' is being used here in a rather technical sense, namely 'ego alien', which is a term sometimes used (or which used to be used) to indicate mental contents which are perceived, or felt, by the person to be external (or alien) in origin, rather than 'home grown'. This is important here because it is compatible with psychotic symptoms.

this point. Staff noted that Mr P had no relationships with other patients and that he seemed to dislike being with other people. It was noted that Dr M1 "*felt it would be a positive sign if [Mr P] admitted that some of the things he does say are overdramatic. Overdramatisation is a borderline trait*". Mr P was being prescribed flupentixol depot 80mg fortnightly, plus as required administration of droperidol[22] up to 50mg daily.

5.43 On 20 October Mr P's detention under the Mental Health Act was renewed under the then legal category of psychopathic disorder.

5.44 In late 1999 it was concluded that Mr P's experiences were not related to schizophrenia. Care plans referred to "*voices*" (shown as such), and that Mr P's "*presentation tends to suggest the contrary to his verbalisations of command hallucinations*".

2000 – Ravenswood House

5.45 In early January Mr P was moved from the admission ward. He was described at this time as "*dependent",* he had been reporting violent fantasies, and "*frequently complained of headaches and requested painkillers"*. His other symptoms were noted to be anxiety and personality related, and staff recorded that they felt his fantasies were unlikely to be acted out. At a case conference he said that he had faked seizures and kidney pain. Staff noted that he had been speaking to his 11-year-old son.

5.46 Toward the end of January staff noted that Mr P had a "*history of frequent use of [GP] services … he has feigned seizures and kidney pain … pricked his finger and put blood in his urine … picture beginning to emerge is that of someone quite dependent…*"

5.47 During February and March staff noted that Mr P had experienced command hallucinations, some of which had told him to kill staff.

5.48 On 8 April Mr P visited his father, this is the first direct contact we have noted for some considerable time.

5.49 On 3 May Mr P's detention under Section 37 Mental Health Act (1983) was renewed under the then legal category of psychopathic disorder.

5.50 At the end of May a case conference was held. Mr P was still reporting command auditory hallucinations and violent fantasies (which could be enjoyable or distressing), and had stated he felt like killing someone. However there had been no incidents of self-injury for more than six months and Mr P was granted unescorted ground leave. His medication was

[22] *Droperidol is a sedative and anti-nausea medication*

flupentixol 80mg fortnightly, plus droperidol 25mg, and thioridazine[23] 100 mg daily.

5.51 In mid-September Mr P visited his former partner Miss Z1 and his son, LR who at this time was approximately eight years old. Around this time staff noted a discussion about the "*voices*" heard by Mr P, noting "*Colleagues indicate some conjecture as to genuineness of his account … not the typical presentation*".

5.52 On 25 September staff "*using prn medication to full dose. Feels some staff imply to him he doesn't need it*".

5.53 On 4 October a case conference was held. Mr P had reported masturbating to fantasies and said he thought he would eventually kill someone. Staff noted "*increasing*" violent thoughts and requests for medication but "*his honesty with respect to his reports of anger, voices and fantasies were doubted …*". Psychometric tests were considered to be invalid because analysis of his ratings significantly indicated that he was exaggerating symptoms. Diagnosis was noted as borderline personality disorder, with no evidence of psychosis. Mr P's reported hallucinations were considered to be a learned behaviour to get a response from staff "*…he demonstrates he wants the security of a hospital …he is not itching to get out… he doesn't think he will manage outside … discrepancies in some parts of his history…"* Medication at that time was flupentixol decanoate depot 80 mg fortnightly, and chlorpromazine 250 mg daily.

5.54 In November staff noted that Mr P had "*constant violent thoughts*" and that he had been seen obtaining medication from another patient, claiming he had been doing so for weeks.

5.55 In late December Mr P reported taking an overdose of diazepam or lorazepam that he had stolen from the ward.

2001 – Ravenswood House

5.56 On 24 January a case conference took place. It was again noted that psychometric testing had indicated that Mr P had exaggerated his symptoms, however there had been little change in his presentation since admission. Mr P had not been using ground leave and had used community leave only once. He was noted to have "*poor coping skills*", was not fully engaging with staff and did not appear motivated to change stating he had no intention of abstaining from drugs in future. The meeting noted "*The reports he gives to different staff members are inconsistent …he gets a 'buzz' on prescribed medications …has stated that he made up symptoms for GPs in order to get medications … feels that he would like to stay where he is …inability to face his problems … how little he has changed since admission … It is felt that he is learning that he is allowed to have his drug addiction on the unit …*". An

[23] *Thioridazine is a medication used to treat certain mental or mood disorders such as schizophrenia. The medication helps a patient to think more clearly, feel less nervous and take part in everyday life. It can also help prevent suicide in patients likely to harm themselves and reduce aggression and the desire to hurt other people.*

MCMI-III[24] was completed that noted that Mr P's response reflected "*extreme degree of self-disclosure and a tendency to over-report behavioural and emotional difficulties…reports more severe symptoms for borderline personality disorder, but somewhat less paranoid symptoms…*"

5.57 In March Mr P was cautioned for theft (we believe he stole drugs from the ward) and in April he undertook his second home visit.

5.58 In May another case conference noted that Mr P continued to lack the motivation to go out on a regular basis with staff citing a *"gross lack of activity*". It was noted that he was visiting his father regularly, but it is unclear how frequently this was taking place, given that the previous month he had completed only his second home visit. It was recorded that Mr P believed that another patient was a "*nonce*"[25] and therefore was a legitimate target for Mr P. Mr P gave staff "*the impression that he is content to remain within institutional care indefinitely*". Tests noted Mr P had a fatty liver with abnormal liver function test results. Medication remained flupentixol decanoate depot 80 mg fortnightly and chlorpromazine 150 mg daily. Mr P's detention was renewed shortly afterwards, with the then legal category psychopathic disorder.

5.59 On 29 June Mr P set fire to clothing in his room and took an overdose. This was linked to a refusal to prescribe specific medication (quetiapine[26]) two days earlier. He was moved to a different ward (presumably to permit more intensive observations for a period of time) but three days later (on 2 July) he was transferred back to his original ward. By now Mr P was prescribed quetiapine.

5.60 On 12 September a case conference was held. Staff noted that Mr P was frequently asking for changes to his medication. At this point he was prescribed quetiapine 400mg daily, chlorpromazine 50mg daily, plus up to a further 100mg daily as required. Mr P continued *"to work on coping with psychotic symptoms … difficulty in separating genuine symptomatology from manipulative illness behaviour*".

5.61 On 3 December he stated he was hearing a voice and was going to kill someone and requested diazepam.

5.62 On 12 December, following a meeting with Mr P, Dr M1 recorded that he believed Mr P was "*untreatable and meds [medications] will be discontinued*".

2002 – Ravenswood House and Broadmoor

5.63 30 January staff noted that Mr P was angry that he had not seen a doctor when requested. Mr P wanted to smash things up and kill anybody who

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[24] *MCMI-III (Milllon Clinical Multiaxial Inventory-III) is a psychological assessment tool that provides information on personality traits and psychopathology, including specific mental disorders.*

[25] *Nonce is a slang word used to describe a sexual predator, particularly one guilty of offences against children.*

[26] *Quetiapine is used to treat bipolar disorder and schizophrenia.*

comes in his way, also that he was hearing a voice telling him to kill himself. Staff noted "*This is his usual presentation".*

5.64 Mr P again expressed frustration about a lack of support from staff on 6 February.

5.65 A report by Dr M1 on 8 February noted that Mr P "*has often been prescribed medication, more to satisfy his own need to be taking medication in the light of poor coping skills rather than on our advice for the specific treatment of his symptoms … has frequently become dependent on medication … has obtained medication from other patients …*". Dr M1 (who was Mr P's responsible medical officer) had written that he had told Mr P that if his detention was lifted by the Tribunal, he would discharge him with four days' supply of medication, as "*as he could not be safely accommodated … informally*".

5.66 On 20 February a psychologist noted that Mr P "*has a history of exaggerating symptoms… motive for this is not clear*". The information indicates that Mr P's father did not come across as neglectful, and there was "*a difference in perception of his childhood between father and [Mr P]*". Mr P stated that the Mental Health Review Tribunal reports contained lies.

5.67 On 2 April Mr P handed over a car key to staff. He said that the car was owned by another patient, and that he was turning over the engine for him. (It is of note that he later claimed he had his own car when at Ravenswood, unknown to staff). Mr P reported distress about wanting contact with his son, and he subsequently had one-to-one time with his primary nurse. Later that day Mr P attacked a fellow patient (Patient A) with a table knife, stabbing him in the face very near to his eye. Mr P was verbally abusive and continued to be hostile. He stated that the victim was a rapist, and he had no regrets about attacking him. Mr P continued to express thoughts of harming others and voices commanding him to do that. He said he felt very angry, with violent racing thoughts, an impulse to attack and harm someone, and that he had been "*wound up for weeks*". Mr P said that he had been angry about not being able to see his psychiatrist (other reports say 'doctor', because he felt non-specifically unwell) or contact his son, which he apparently identified as a trigger that day. He said that his victim was the "*best candidate*" and that the victim deserved it. Mr P was moved back to the admission ward.

5.68 The following day (3 April) Mr P said that the Patient A "got in the way" and that the assault was a result of his (Mr P's) frustration, "*annoyed about [Dr M1] lying about the MHRT report … commands in his head, all the time, to assault all males (staff and patients) on the ward …no remorse … no evidence of psychosis … [Dr M1] returns on Friday … not for referral high security currently …*".

5.69 On 4 April it is noted that Mr P said that the assault was "*silly*" and "*undeserved*" and that there was no evidence of mental illness.

5.70 On 5 April Mr P claimed he had not planned the assault.

5.71 On 8 April Mr P gave "*different reasons for the act*".

5.72 On 9 April Mr P said that there were things he had never told anybody that he was going to have to address in therapy.

5.73 On 11 April he told a music therapist he had asked to see a doctor because he couldn't handle his feelings. He had taken a knife from the kitchen with intention of self-harming, had seen the fellow patient sitting alone, thought "*he'll do*" and attacked him. "*[Patient A] is a rapist which I hate or anything to do with rape because I was violently raped …when I was 18, me and two others beat this man to death and threw him off a motorway bridge."*

5.74 The following day it was noted that Mr P reported continuous thoughts and voices telling him to hurt people and that he felt he was on the verge of losing control, "*Says precipitated by disclosing to staff that he was raped when he was 12".*

5.75 On 16 April a doctor recorded that Mr P was "*resentful because I have not prescribed the medication he wanted … fed up with all mental health services … unable to focus on any other subject but medication … sees his present situation and all his life as due entirely to other people and external influence*".

5.76 On 17 April staff noted that there were many doubts regarding the authenticity of Mr P's reported history.

5.77 On 18 April the music therapist noted that Mr P had no remorse for his victim, "*only for himself … needs to feel respected … reinforces he can take care of himself and is no longer vulnerable to be dominated … feeling very violent towards [RMO]*".

5.78 On 1 May staff noted that Mr P was "*still blaming nursing staff and doctors [for the assault]. Not feeling guilty … staff should have acted on his distress and requests*".

5.79 On 27 May nursing staff reported a plan for a Patient A (Mr P's victim on 11 April) to occupy staff by "kicking off", while Mr P would then stab another patient with a knife.

5.80 At the end of May Mr P's detention under Section 37 Mental Health Act (1983) was renewed on the grounds of psychopathic disorder, without mental illness. A medical report noted:

> *"…has expressed remorse for the attempted stabbing and has said that it will never happen again … mental disorder is psychopathic disorder … a personality disorder of predominantly emotionally unstable and dissocial type…".*

5.81 On 5 June staff discussion the possibility of referring Mr P to Dr G1, consultant forensic psychiatrist and psychotherapist at Broadmoor.

5.82 On 12 June it was noted that clozapine had been mentioned to Mr P and that he "*appears to be very keen on the idea*". Mr P's doctor later agreed to a trial of clozapine.[27]

5.83 On 14 June Mr M1 sought advice from the General Medical Council and the Medical Protection Society about whether to report Mr P's disclosure of homicide.

5.84 On 16 June the Clozaril Patient Monitoring Service advised that it was unable to register Mr P as a patient because his diagnosis was not treatment-resistant schizophrenia.

5.85 On 19 June staff noted that Mr P was "*eager to start clozapine*".

5.86 On 24 June a referral was made to Dr G1 for advice. The formal referral letter to Broadmoor was sent less than a fortnight later. The letters were very similar (identical in parts) but the first letter did not mention the threat to kill another patient. The letter seeking advice noted "*he has found it difficult not to be reliant on prn medication … has also obtained medication from other patients … unwilling to have his prn reduced"*. At that time Mr P was prescribed quetiapine 300mg, sertraline 200mg, and as requested haloperidol and lorazepam. The letter asked for an opinion on whether clozapine might be of use.

5.87 On 26 June staff noted that Mr P had voiced thoughts of killing another patient, Patient B. Mr P had repeated his claim that he murdered someone and maintained this was justified but said he would deny the offence to police. Staff also noted that Mr P "*believes [Patient A] wants info about offence so he can be reported to police … not really worried about the consequences of anything he might do… feels threats of violence work in this unit …"*

5.88 On 30 June Mr P made a home visit.

5.89 On 3 July a specialist registrar referred Mr P to Broadmoor, noting:

> *"dependency on substances has been an issue throughout his stay … thoughts of wanting to kill people … occasionally reports hearing a male voice and he claims that the voice is called Hans Blood … [while on admission ward] also disclosed he was raped at the age of 12 and was later involved in the death of the perpetrator of the rape … he has said that this is one of the reasons he feels like killing males and feels particular malice towards those he believes to have committed a sexual offence … approximately two weeks ago started to plan the attack which [he] hoped would result in the death of another patient. [He] involved other patients … in this planned attack …"*

[27] *Clozapine is a drug used to treat schizophrenia in patients who have been unresponsive to, or intolerant of, conventional antipsychotic drugs. It is also occasionally used off licence in certain other clinical pictures in specialist settings, including severe personality disorders.*

5.90 On 10 July at the ward round meeting staff noted Mr P "*wants to kill staff and patients … [and] himself … handed in a ligature … staff make sure not to talk about murder / rape themselves; can talk about feelings …*"

5.91 On 11 July Mr P was prescribed clozapine, reaching a dose of 500mg daily.

5.92 On 24 July in a medical report a specialist registrar noted that since being back on the admission ward Mr P had revealed events from his past for which he would require psychological help. The doctor noted that a referral to a psychotherapist at Broadmoor had been sent and that Mr P continued to have violent thoughts about killing another patient. It was also noted that Mr P had been prescribed clozapine off licence to help him gain control over his thoughts.

5.93 On 2 August Mr P told a music therapist that a nurse had called him "*[surname] boy*", after which he threatened to fashion a weapon from plastic and stab the nurse (he apparently handed a weapon in). Mr P believed staff may have looked down on him because they knew he had been sexually abused. Mr P referred to the "*knife incident*" with Patient A and said that he felt vulnerable around "*these types of offenders*".

5.94 It appears that around this time Mr P was seen by Dr M8, consultant forensic psychiatrist from Broadmoor.

5.95 On 7 August the dose of clozapine was increased to 300mg daily.

5.96 On 13 August the dose of clozapine was again increased to 325mg.

5.97 On 14 August Mr P stated he felt much better on clozapine and that he had received a telephone call from his son, aged 14 years.

5.98 On 21 August Mr P made a home visit and at the ward round meeting it was noted that Mr P had expressed desires to kill two named individuals and to disembowel a member of staff.

5.99 On 2 September it was noted that when Mr P was speaking to male patients or members of staff he considered torturing them, cutting them up, and killing them and that he gained some pleasure from these thoughts. It appeared that the frequency of these thoughts had reduced since on Mr P had started clozapine and that Mr P had reported that the "*voice in my head*" had also reduced frequency since starting on clozapine.

5.100 On 4 September the dose of clozapine was increased further to 400mg.

5.101 On 9 September a Mental Health Review Tribunal noted that after Mr P had been transferred back to the admission ward he had made plans to kill another patient and that he had made disclosures about his past that persuaded the medical team to refer him to Broadmoor.

5.102 On 17 September after Mr P had gone on escorted ground leave, he reported thoughts of making a severe assault on his escort, including "*eating his*

insides … one male voice, Hans Blood, telling him to harm people, immediate thoughts of harming [male escort]".

5.103 The following day the dose of clozapine was increased again to 450mg and staff noted that Mr P "*seems to be pushing for acuphase*"[28] and said "*no-one's taking me seriously, if the drugs don't kick in soon, I will want to wreck the place …*". Mr P made several requests to receive acuphase, stated he would have to be given it if he kicked off and asked to see a doctor.

5.104 On 20 September Mr P was seen by Dr G1 from the psychotherapy department at Broadmoor. Dr G1 stated that she agreed entirely with Mr P's consultant that his diagnosis was "*clearly that of severe personality disorder with secondary drug misuse*". Mr P had told her he had a conscious wish to hurt others, which he linked to having been raped by a trusted adult, and that he sometimes believed others could read his mind. He reported that chlorpromazine had helped, and that clozapine also helped. Dr G1 mentioned some previous head injuries (and their potential impact on emotional dysregulation), which had not been highlighted by other clinicians. Dr G1 referred to trauma-related emotional dysregulation (with hyperarousal) and to sadistic fantasies (to improve mood and feel powerful). Staff at Ravenswood House told her they experienced Mr P as "*incredibly dangerous*".

5.105 On 30 September staff noted that Mr P had been wearing dark glasses (a later entry states that Mr P wore them *"to look different from other patients"*). Mr P was experiencing constant urges to kill and that when he told staff of these feelings staff are "*removed to duties elsewhere*". It was noted that Mr P felt that killing someone would make him feel powerful, "*I only think of myself".* Mr P assumed no responsibility for his actions, felt blameless and a victim. Staff noted that he continued to experience the voice of "Hans Blood" telling him to harm self and others. Medication at that time was clozapine 425mg but Mr P was making "*constant requests for benzos and chlorpromazine*".

5.106 On 2 October a Care Programme Approach meeting was held. It was noted that Mr P had reported command hallucinations telling him to kill others "*patients that annoy him*", and that medication had helped with his strange thoughts, including that other people could read his mind. It was also noted that he had been referred to Broadmoor for a second opinion.

5.107 On 9 October Dr G1 completed her report.

5.108 On 12 November a report by Dr M8 interpreted Mr P's behaviour as being in the early stages of the acting out process of sadistic fantasies. Three days later it was confirmed that Mr P would be admitted to Broadmoor. By this time his clozapine dose was at 475mg.

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[28] *Clopixol acuphase is an antipsychotic drug that is used in the initial treatment of short-term psychoses including mania or increases in the severity of existing psychoses.*

5.109 On 18 November Mr P was placed on line of sight observations and had no leave. A nursing care plan noted that he displayed "*histrionic traits of ingrained violent behaviour … fantasies are about killing …*".

5.110 19 November Mr P was informed about the planned admission to Broadmoor.

5.111 On 20 November it was noted that Mr P had asked to change his medication to clopixol. He was prescribed zuclopenthixol 60mg daily plus 100mg depot, plus as required zuclopenthixol 40mg and diazepam 30mg.

5.112 On 26 November it was recorded that Mr P understood from Dr M1 that he was "*untreatable so meds [medications are] to be discontinued*". However, Dr M1's entry from 20 November does not mention this.

5.113 On 30 November it was noted that Mr P was prescribed clozapine 500mg in addition to the medications described in paragraph 5.111 above. Mr P was highly over-sedated, but it was still noted that he reported thoughts of killing several people and ripping their throats out. *"[Mr P] obviously ups the ante until he has taken his full quota of [as required] medication, no matter how high the dose, has little effect on his mental state*". The as required diazepam was reduced to 45mg, and zuclopenthixol to 40mg.

5.114 On 4 December clozapine was stopped, due to a lack of benefit "*not helping at all*" and adverse physical effects (persistent tachycardia)[29]. Although soon after Mr P was quoted as saying he "*felt better on clozapine, thought it was helping".*

5.115 Mr P was transferred to Broadmoor (run by West London Mental Health Trust). On arrival he was prescribed zuclopenthixol 60mg plus as required diazepam up to 45 mg daily. Mr P's legal detention category was psychopathic disorder. Mr P was first nursed on Luton ward and while here he reported that he and accomplices killed the man who sexually assaulted him, there were no reports to suggest that this claim was accurate. Mr P was unable to account for his aggression towards the Ravenswood patient and he frequently requested changes to his medication.

2003 – Broadmoor

5.116 Throughout January Mr P continued to report graphic thoughts of violence and command hallucinations from a voice of "*Hans Blood*" telling him to kill people and a specific patient (Patient C). He repeated the claim that he and others had kicked his abuser to death when he was aged 18 years. He was prescribed chlorpromazine 400mg daily in addition to his other medications.

5.117 During March he told staff that Broadmoor was "*c**p*", that staff at Ravenswood House had more time for him and that he wanted to return there. At an admission meeting he reported that when he was at Ravenswood

[29] *Tachycardia is a heart rate that is faster than normal while the person is at rest. In general (in adults) a resting heart rate of over 100 beats per minute is accepted as tachycardia.*

House he had used medication prescribed for other patients. Staff noted that the police should be contacted and that:

> *"His difficulties suggest he may have been subject to more extensive abuse as a child. In view of his varying accounts of [rape aged 12] it is unlikely that this account, or his account of having subsequently killed the perpetrator, are truthful. They may serve as a metaphor, which allows him to have mentally killed off his abuser and to deny more extensive experiences of sexual abuse, possibly by his father".*

5.118 On 19 May a social circumstances report states that Mr P "*… underestimates the seriousness of his behaviour … which led to his admission [to high secure hospital]*".

5.119 A Care Programme Approach report dated 23 May, written by Dr A3, consultant forensic psychiatrist at Broadmoor stated that if the Mental Health Review Tribunal were to discharge Mr P, he wanted to go to Portsmouth, not Taunton.

5.120 An admission case summary also written in May stated that the likeliest explanation of auditory hallucinations was fabrication for the purpose of obtaining medication and care, and avoiding responsibility for his behaviour. Mr P was noted to often have violent thoughts towards patients who he believed had offended against children. It was considered that self-reported rape was unlikely to be true, because of Mr P's varying accounts, and that instead he may have been more extensively sexually abused, perhaps by a family member. Mr P was diagnosed as having personality disorder with dependent, antisocial and borderline traits, and as not having a mental illness.

> *"willing to talk but not about anything in depth and stated he would prefer to do this when he was back at Ravenswood House … only mentioned being raped … as an afterthought which raised additional doubts about the truthfulness of this account … frequently requested alterations to his medication …"*

5.121 On 27 May Mr P was moved to the treatment ward (Glastonbury Ward). His prescription at this time was chlorpromazine 400mg and sertraline. He continued to report command auditory hallucinations.

5.122 On 5 June Mr P's detention renewal refers to "*severe*" (the reference to severe being new) personality disorder with paranoid and borderline features.

5.123 On 1 July Dr A3 requested information from Ravenswood House about Mr P's previous disclosure of homicide. Mr P had previously refused to give any further details, stating that neither he nor his co-assailants should be punished, and that he would deny everything to the police. A letter from Ms P3, consultant clinical psychologist stated:

> *"His rationale for the assault on a male patient … was that the patient was a rapist… [He] was always disinclined to look in detail at the content of his thoughts … To discuss [sexual abuse] further would mean revealing more*

information which could lead to identification [of the putative homicide victim] … to move on he needs to talk, but to talk could result in him being charged with a serious offence … [Mr P] stated that he was the instigator of the attack and that he did not tell the other two people of his reason for wanting to kill this man.

… [He] was ambivalent about going to Broadmoor, but would have preferred not to … he hoped that by talking about his past, this would reduce the chances of [transfer] … unprompted, he launched into an account of the sexual assault … By this account the assault would have had to have been some years after the age of 12.

… If [his] account is true, then the timing of the disclosure needs to be explained. This would be after he had assaulted [patient], who he believed to be a sex offender, and to explain the reason for the attack.

… On admission, [he] gave the impression of exaggerating symptoms and clearly at some level he wanted to be in hospital …on at least two occasions [he] has engaged in behaviours … which resulted in [ward transfer]. It is thought that these occasions were associated with [him] wanting an increase in medication …"

5.124 In August a social circumstances report noted that Mr P wanted the Tribunal to recommend a move back to a medium secure hospital (presumably Ravenswood House).

5.125 The Mental Health Review Tribunal hearing on 15 September noted that Mr P was detained on the grounds of psychopathic disorder and that he felt he could be treated in medium security.

5.126 On 30 December Mr P was secluded for 13 days after complaining of intense voices instructing him to harm others or himself. Around this time Mr P's father visited him.

2004 – Broadmoor

5.127 On 4 February Mr P was secluded again after assaulting staff, when again he complained of hearing commanding voices. Mr P attempted a further assault on staff just five days later.

5.128 He was transferred to a high dependency unit (Henley Ward) and nursed in seclusion on 12 February. Medication at this point was zuclopenthixol decanoate 600mg weekly, trifluoperazine[30] 25mg, chlorpromazine and fluoxetine.

5.129 On 28 May Mr P's detention renewal again refers to severe personality disorder with borderline, paranoid, dependent and antisocial features (i.e. psychopathic disorder only).

[30] *Trifluoperazine (also known as Stelazine) is a first generation, or typical, antipsychotic medication.*

5.130 A Care Programme Approach meeting on 16 June noted that Mr P felt that his transfer was a punishment for the assault. He said that he had gone to staff because of voices but had not been offered time or medication, so he went to kitchen and took a knife to stab a patient he suspected of being a sex offender. Mr P said he regretted the act. Medication at this time was zuclopenthixol 600mg weekly, chlorpromazine 800mg daily, and fluoxetine. It was also noted that Mr P had repeated his homicide claim to staff at Broadmoor.

5.131 On 18 June Mr P was referred for a psychotherapy opinion.

5.132 Throughout July Mr P continued to report voices instructing him to harm himself and other people.

5.133 On 1 August he threatened to kill two members of staff in response to reported voices. Following this Mr P's prescription of zuclopenthixol depot and chlorpromazine was tapered and then stopped.

5.134 On 3 and 17 August Mr P was assessed by Dr M3, specialist registrar in forensic psychotherapy. Dr M3 was supervised by Dr G1 and his report repeated much of her earlier assessment letter.

> *"appeared somewhat blunted in affect … heard voices that told him to kill himself and harm others … he resists the voices … he disagreed [with primary diagnosis of personality disorder] and thought he had a mental illness … In some respects he seemed to hold his offending history as a badge of honour … It is quite clear that [he] has antisocial personality disorder … It would seem likely that [he] has suffered from depressive illness for a long time …drinking heavily and … head injury … would have made it harder for him to regulate his feelings … a very paranoid view of the world... "*

5.135 It appears that the view held by Dr G1 and Dr M3 was that the abuse that Mr P reportedly experienced led to a reduction in Mr P's ability to regulate his mood and state of arousal, and hence hyperarousal and dissociation. They also felt that the abuse was linked to the development of fantasies to manage feelings of helplessness and powerlessness. Mr P was placed in the waiting list for individual psychotherapy.

5.136 On 15 September Mr P's prescription for depot was also discontinued.

5.137 Notes of a discussion that took place on 2 October indicate that Mr P's diagnoses were paranoid schizophrenia, mixed personality disorder (dissocial and emotionally unstable - impulsive type). It was also noted that Mr P may have been abusing his medication, using it as he would do an illicit substance. He was described as "*is never without auditory hallucinations day and night …*".

5.138 On 14 October the specialist registrar noted that he thought that Mr P had a mental illness, and not a personality disorder. It was noted that Mr P had said

he had stabbed Patient A (at Ravenswood House) because he knew Patient A was a paedophile. Mr P said that he had stabbed nine people.

5.139 It appears that in December Mr P was transferred out of the high dependency unit to Glastonbury Ward. There is a reference to consideration of clozapine but it is unclear if this was prescribed.

2005 – Broadmoor

5.140 In February/March Mr P asked for enhanced observations due to voices.

5.141 It appears that in March Mr P was started on a trial of amisulpride.[31] It was thought that Mr P was exaggerating symptoms in order to get benzhexol.[32]

5.142 In April Mr P was transferred to a district general hospital after ingesting clozapine that he obtained by pressuring another patient to hand it over. He was returned to Broadmoor within eight hours. It seems he then went to Dunstable ward (the "infirmary") where the antipsychotic medication was stopped, however "*within days he was again hearing voices and displaying psychotic symptoms*". Mr P reported a resurgence of the voice of "Hans Blood" and staff noted that he had "*limited coping skills … pursuit of medication at times of psychological difficulty … very keen to return to [Ravenswood House]...".* Mr P was prescribed venlafaxine[33] only.

5.143 On 5 May Mr P's detention was renewed on the basis of psychopathic disorder with the form specifying disorder of personality with severe mood changes and episodes of hearing voices.

5.144 Throughout June Mr P continued to report hearing "Hans Blood", telling him to harm others or himself. He asked for antipsychotic medication to be reinstated. A Care Programme Approach report dated 16 June stated that Mr P had displayed no violent incidents in the previous six months but that his reports of hearing a second person or command voice at times of stress "*continue to be seen in the context of a personality disorder, rather than viewed as indicative of a psychotic illness".*

5.145 On 18 July Mr P was reviewed by Dr M1 from Ravenswood House who considered that a return to medium security would be premature.

5.146 On 28 July Mr P was allowed a home visit on compassionate grounds.

5.147 In August Mr P was prescribed valproate.[34]

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[31] *Amisulpride is an antipsychotic medication used to ease the symptoms of schizophrenia*

[32] *Benzhexol is used to treat some symptoms of Parkinson's Disease but it is also sometimes used to treat some side effects caused by antipsychotic medication.*

[33] *Venlafaxine is an antidepressant medication, sometimes used to treat anxiety and panic attacks.*

[34] *Valproate is used to treat epilepsy and bipolar disorder*

5.148 In late September Mr P was again transferred to a district general hospital where he spent four days with suspected appendicitis.

5.149 On 2 October Mr P's weight was 121kg.

5.150 A social circumstances report on 11 October stated that Mr P felt he should return to a medium secure unit (such as Ravenswood House).

5.151 By 17 October Mr P had disclosed what abuse he had suffered and the identity of his alleged abuser, and said he was prepared for police and local authority involvement in order to protect others. However, electoral roll and death register searches were negative.

5.152 A Mental Health Review Tribunal hearing on 26 October agreed Mr P's diagnosis to be psychopathic disorder, noting he had "*a tendency to insist on medication which is not required for his treatment*".

5.153 In November Mr P started dialectical behaviour therapy (DBT).[35]

5.154 On 14 December Mr P reported violent thoughts and said he felt he was not being helped. He stated that using violence to achieve his ends had always worked, and hence he always used it.

5.155 On 18 December staff noted that Mr P appeared elated and restless, had reported racing thoughts, and thoughts of harming himself and others.

2006 – Broadmoor

5.156 On 5 January Mr P was secluded and shortly afterwards (8 January) he was transferred back to the high dependency unit (Henley Ward) after making threats to harm others. He was placed on enhanced observations after reporting thoughts of violence directed at specific staff and patients. Mr P said that he had threatened others because he felt he had not received enough support from staff when approaching them after therapy sessions in which he had discussed rape. He claimed he had had a lifelong interest in violence. Staff suspected him of exchanging medication with other patients and flupentixol depot was commenced on 26 January, followed by clomipramine[36] to treat the obsessive features of Mr P's symptoms.

5.157 In late March Mr P referred to thoughts of harming two specific patients and one staff member.

5.158 As a consequence of the amendment to the legal categories underpinning Mr P's detention, on 13 April Mr P's detention was changed to "*mental illness*" as well as "*psychopathic disorder*" and on 30 April Mr P's detention was renewed on this basis with his consultant psychiatrist having noted that Mr P

[35] *Dialectical behaviour therapy (DBT) is a specific type of cognitive behavioural psychotherapy to treat borderline personality disorder.*

[36] *Clomipramine is a tricyclic antidepressant and is used to treat people with obsessive compulsive disorder*

"*had periods of psychotic symptoms and obsessive symptoms and serious symptoms of a depressive nature*".

5.159 On 11 May Mr P made a visit to his father on compassionate grounds.

5.160 On 14 May Mr P reported that a voice was telling him to kill himself and others. He said he had tried to strangle himself with a shoelace. He equated "Hans Blood" with the devil and believed he could read the minds of others. He reported that he avoided watching television because when he thought about something it then appeared on the television. Mr P said he believed staff and patients talked negatively about him and might do him some harm, said he could control the minds of others. Clozapine was reconsidered. Said he had tried to strangle himself with a shoelace.

5.161 In June Mr P reported that he sometimes enjoyed violent fantasies and intimidating others with them, but at other times he did not enjoy them and found them distressing. He was seen by a trainee (medical) forensic psychotherapist and later was prescribed clozapine, alongside psychoanalytic psychotherapy.

5.162 On 10 July Mr P was seen by Dr M1 who attended Mr P's Care Programme Approach meeting. It was noted that Mr P believed he should return to medium security, and then to the community not too long after that. Dr M1 believed that Mr P "*still has outstanding difficulties in coping … drug-seeking behaviours … propensity to express distress via reporting auditory hallucinations … recently required transfer to the HDU … very poor insight and unrealistic expectations …*". Dr M1 was also doubtful of the presence of psychotic symptoms as mentioned in the medical report. Mr P refused to attend the Care Programme Approach meeting because of Dr M1's view of him. Contact forms were sent to Mr P's former partner and their son (Miss Z1 and Mr Z2) but were not returned and so contact with them was not established.

5.163 On 17 July Mr P visited his father at home.

5.164 A social circumstances report dated 4 September noted that Mr P "*continues to hear voices telling him to kill himself or seriously harm others*".

5.165 On 22 September Mr P was transferred from the high dependency unit back to Glastonbury Ward.

5.166 In early December Mr P asked to be secluded after visiting his father. Around this time Mr P said that he regretted lying to the doctor about feeling well and staff noted that Mr P had:

> *"expressed delusional beliefs that a nurse was placing thoughts in his head to kill another patient … stated that he was the devil's son and will be punished if he does not do what he is asked. Thoughts of pulling people's hearts out which makes him immortal, stabbing them and watching them die …"*

5.167 On 11 December Mr P demanded medication on the grounds of boredom.

5.168 On 14 December Mr P claimed to have murdered someone, and then said he was joking.

2007 – Broadmoor

5.169 A nursing report dated 3 January and prepared for a Care Programme Approach meeting stated that Mr P was suspected of bullying other patients and that he "*has expressed continuous auditory hallucinations telling him to kill specific individual patients and staff from the day he was transferred back from a [HDU] … dominant person on the ward*". However ,it was generally stated that Mr P appeared to be doing well in January through to April.

5.170 In April Mr P visited his father. Due to significant weight gain (at one point Mr P's weight had increased to 141kg from 121kg), clozapine was reduced rather than stopped, because of perceived "*great benefit*", but was later stopped, and replaced with risperidone[37] depot 50mg fortnightly. Mr P requested contact with his son Mr Z2, who by now was aged 18 years.

5.171 On 9 May Mr P's detention was renewed on the basis of mental illness (psychotic symptoms) and psychopathic disorder. It was noted that he was due for transfer to medium security, but that he had a "*history of being non-compliant resulting in resurgence of psychotic symptoms when he is at risk to himself and others*". It was also noted that Mr P had lost about 13kg due to an undiagnosed bowel problem.

5.172 On 31 May Mr P's consultant psychiatrist at Broadmoor asked Dr M1 from Ravenswood House to assess Mr P for medium security because of his "*settled mental state over a protracted period".*

5.173 On 20 June Dr M1 assessed Mr P and noted "*We believe that [Mr P] is not quite ready yet for a transfer back … His improved ability to cope needs to be tested … in more demanding circumstances …*". Dr M1 also noted that Mr P's visits to his father visits involved four escorts, one driver and handcuffs to one wrist. Dr M1 stated that the impact of the "*new diagnosis*" of mental illness should be reflected in Mr P's risk management and relapse prevention documents and that Mr P's account of the pre-referral assault was not accurate. It was noted at the Care Programme Approach meeting that staff at Ravenswood House were concerned that the dual classification "*impacted on risk management*". It appears that Mr P was prescribed valproate (in addition to risperidone) at this time.

5.174 On 28 June Mr P presented as elated, complaining of sleep deprivation and loss of concentration. The dose of valproate was increased.

5.175 On 13 July Mr P was administered a risperidone injection and valproate.

[37] *Risperidone is an antipsychotic medication used to treat schizophrenia, bipolar disorder and other psychological disorders.*

5.176 On 20 September Mr P's consultant psychiatrist and responsible medical officer Dr S4 wrote to Dr M1. Dr S4 advised that staff were trying to contact Mr P's son, so far without success, but that Mr P was settled and compliant.

5.177 On 6 October Mr P was secluded after making threats to two members of staff.

5.178 On 12 October Dr M1 from Ravenswood House stated that community leave from high secure hospital (Broadmoor) should be in place before transfer to medium security (Ravenswood House) could be agreed.

5.179 In November Mr P reported violent thoughts about people who had harmed children.

5.180 In December Mr P was accepted for transfer to Ravenswood House (medium security). By this time, it appears that clozapine had been reinstated.

2008 – Broadmoor

5.181 On 23 April Mr P's detention was renewed on the basis of mental illness (paranoid schizophrenia) and psychopathic disorder (personality disorder; antisocial and unstable type).

5.182 A Care Programme Approach meeting held on 28 May noted that Mr P was consistently settled.

5.183 In July it was noted that Mr P was on the waiting list for transfer to Ravenswood House.

5.184 A social circumstances report dated 24 November stated that Mr P "*readily accepts that he has abused prescribed medication in much the same way as illicit drugs*" during hospital admissions. Mr P had been consistent for several years in his belief that he did not need to be in a high secure hospital and that his sadistic homicidal fantasies "*come and go*". Mr P told a psychologist that "*he killed the man who sexually abused him in his mind*". During November it was noted that Mr P's clozapine levels had increased after he stopped smoking, so the dose had been reduced and Mr P's responsible clinician reported that the mental illness was recurrent and relapsing. However Mr P said he had not felt mentally unwell for over a year, and that he no longer felt it was his duty to punish sex offenders. It was noted that Mr P's responsible clinician had stated that *"he has a diagnosis of paranoid schizophrenia with a comorbid diagnosis of personality disorder".* A risk management plan noted as an early indicator "*relapse of mental state with resurgence of auditory hallucinations and paranoid delusions".* The care plan included "*psychotic symptoms*" as an identified need.

5.185 In December a Mental Health Review Tribunal described Mr P as having "*an established diagnosis of schizophrenia and personality disorder*". He was prescribed clozapine and valproate.

2009 – Broadmoor and Ravenswood House

5.186 A medical transfer note dated 13 March gave Mr P's diagnoses as "*schizo-affective disorder and borderline personality disorder*".

5.187 17 March Mr P was transferred back to Ravenswood House. Medication at this time was clozapine 325mg, citalopram,[38] valproate 2400mg daily and this regime had been unchanged "*for over two years*". Mr P's responsible clinician was again Dr M1 and it appeared that Mr P was still had a 'dual category' for the purposes of the Mental Health Act. It was noted that trial leave would be arranged.

5.188 On 12 April Mr P tested positive for benzodiazepines, he was not prescribed these drugs. He later claimed he had bought the drugs from a patient prior to transfer.

5.189 By the time of a Care Programme Approach meeting on 20 May the diagnosis of schizophrenia had been replaced by personality disorder (mixed dissocial and paranoid) with polysubstance misuse. It was noted that clozapine 325mg was prescribed as "*off licence treatment of personality disorder*". Mr P had reported that the medication had helped significantly, and he wanted to remain on it. Mr P's weight at this time was 126kg, with a BMI of 42 indicating he was severely obese.

5.190 On 1 June he was formally transferred from Broadmoor to Ravenswood House (this meant he was no longer on trial leave from Broadmoor) and his responsible clinician continued to be Dr M1.

5.191 In June Mr P indicated that he felt the improvement in his mental health was because of the clozapine and a nursing report stated that his diagnosis was personality disorder. Glucose intolerance was noted at this time and Mr P was receiving depot of 80mg fortnightly. A case summary and risk profile were completed by Dr M4 (first version) that indicated that Mr P's diagnosis was mixed personality disorder with dissocial and emotionally unstable traits. A medical report completed by Dr M1 confirmed that Mr P's treatment was for personality disorder.

5.192 In September Mr P was transferred to a rehabilitation ward (Meon Valley Ward) and his responsible clinician was Dr B3. Later that month there is a report of another patient claiming that Mr P had used new psychoactive substances.

5.193 On 21 December clozapine was stopped and flupentixol decanoate 60mg fortnightly started. There is another record that indicates this took place on 10 November, however it is possible the medication was from or after this date before being finally stopped on 21 December. Mr P's weight at this time was 134kg, and his BMI had increased to 44. Mr P was severely overweight, and suffering from hypertension, dyslipidaemia, and asthma.

[38] *Citalopram is an antidepressant.*

2010 – Ravenswood House

5.194 At a Care Programme Approach meeting on 5 January it was noted that Mr P's diagnosis remained "*mixed dissocial and paranoid personality disorder*" but was "*stable*". Mr P's medication was depot 60mg fortnightly, citalopram, and sodium valproate 2400mg. His responsible clinician had changed again and was now Dr A5 (this was the third responsible clinician since moving to Ravenswood House nine months previously). Mr P was accessing unescorted ground leave but was reluctant to return to the Bournemouth area on discharge. He had lost a kilo in weight since just prior to Christmas was weighed 133kg.

5.195 In late January it was reported that Mr P felt that people were trying to poison him, and he had an urge to hit two patients.

5.196 In March his diagnosis was recorded as "*mixed personality disorder with dissocial and emotionally unstable traits*". An HCR 20[39] risk assessment completed at the time describes thought insertion, thought broadcasting and voices as pseudo-psychosis like symptoms with staff noting "*it is unclear if they are real or exaggerated"*. Staff noted that Mr P was "*definite*" on the PCL-R[40] and was scored as having no mental illness. The meaning of definite here would have been used to indicate that Mr P's score was above the cut off for 'definite psychopathy'. Mr P asked to move wards and to be prescribed diazepam.

5.197 At a Care Programme Approach meeting on 23 March Dr B2 (consultant clinical and forensic psychologist for the Dorset Forensic team, who was attending the meeting) noted that Mr P had reported to her that he had experienced recent flashbacks and nightmares, and that he "*adamantly*" did not want to return to Dorset. It appears that this was because he feared reprisal from a dealer, but also said he had previously been refused treatment at St Ann's Hospital and was angry about that. After being advised of funding issues Mr P agreed to consider St Ann's Hospital. Dr B2's letter states that Dorset forensic team agreed to refer him for psychoanalytic therapy for "*abuse related matters*". Mr P's diagnosis was recorded as "*mixed dissocial and paranoid personality disorder*" and his weight had dropped again to 118kg.

5.198 From April Mr P's depot medication was increased from 50mg, to 80mg and then to 120mg fortnightly. Mr P reported that he was not experiencing current violent fantasies and appeared insightful and motivated. However, this deteriorated later with him reporting psychotic symptoms (including auditory hallucinations), suicidality and thoughts of harming others. He believed staff were inserting thoughts into his head and was thinking about making weapons

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[39] HCR-20 is a comprehensive set of professional guidelines for violence risk assessment and management based on the Structured Professional Judgement (SPJ) mode.

[40] The Hare Psychopathy Checklist-Revised (PCL-R) is a diagnostic tool used to rate a person's psychopathic or antisocial tendencies.

to protect himself. Mr P caused damage to the ward and believed patients were ganging up against him.

5.199 On 5 May a report by his responsible clinician Dr B5 stated that the assault in April 2002 "*precipitated*" the transfer to a high secure hospital eight months later. Staff noted that Mr P had dissocial traits with callous unconcern, irresponsibility and disregard for social rules, low tolerance for frustration, incapacity to express guilt and plausible rationalisations. Mr P demonstrated emotionally unstable traits with emotional instability, poor impulse control, self-harm and threats of suicide, and incapacity to maintain enduring relationships.

5.200 A nursing report dated 8 May noted that Mr P requested one to one time with staff "*approximately four times a day to vent the way he is feeling however he does state he feels that staff are fed up with him …has also stated that on occasions he has had voices telling him to make weapons to protect himself against other patients…*".

5.201 A ward round note dated 11 May stated Mr P was *"… having reduced psychotic symptoms, i.e. paranoia and thoughts of self-harm … Pharmacy suggested that … depot should be increased and if this is not effective then clozapine should be re-introduced and aripiprazole included … attended ward round … would like to recommence clozapine as this would help with his psychotic symptoms …*".

5.202 Mr P saw his responsible clinician Dr B5 on 12 May. Dr B5 noted that Mr P had "*two periods of feeling paranoid and having significant thoughts of self-harm, saying that he feels thoughts in his head are not his own, or other people can read his thoughts (though they do not appear to be of the intensity to consider them first rank symptoms).*" Dr B5 agreed to start clozapine again, although it appears that this was not started immediately because eight days later Mr P reported feeling paranoid *"…believes his thoughts are taken away and someone is putting thoughts into his head, hearing voices of "hans blood" asking him to hurt others … wants to go back on clozapine*".

5.203 This presentation continued with reports on 24 May that Mr P had "*thoughts of harming the staff over the weekend … getting messages from the TV and staff were putting thoughts into his head*". The following day he reported frequent thoughts of stabbing people, with staff noting that the violent thoughts had increased in intensity over several weeks. However, Mr P's diagnosis was not reviewed at this time. Mr P reported on 26 May that he was "*happy to be restarting clozapine"* as he believed the medication took away any violent thoughts.

5.204 The following day Mr P said that he had no further thoughts of harming himself or others and it was noted that the flupentixol depot would be stopped.

5.205 In June Mr P was granted escorted ground leave, then shortly afterwards unescorted ground leave, and community leave. Aripiprazole was added to Mr P's prescription and staff noted "*no continuation of morbid thoughts or pseudopsychotic symptoms*". There is no reference to the fact that

aripiprazole was being prescribed off licence, given that Mr P's diagnosis remained personality disorder.

5.206 A nursing report dated 27 June stated that Mr P had been settled since the clozapine had been reinstated and that he had no thoughts of self-harm or harming others. However the following day staff noted that Mr P had been "*exploiting other patients for tobacco … approaching peers to borrow [money] … very demanding of staff time*".

5.207 At a Care Programme Approach meeting on 29 June it was noted that Mr P had "*…repeatedly stated that he does not want to go to the Bournemouth area*" citing a dislike of the hospital and the area and being a marked man with a price on his head due to a previous incident. Risks from Mr P towards other patients were noted "*…he has been both dismissive of them, and sought to take advantage, by begging for money / cigarettes…*". There are several references to Mr P borrowing and trading on the unit. Mr P's diagnosis was noted as "*mixed dissocial and paranoid personality disorder*" and it appears that Mr P was getting some benefit from the clozapine.

5.208 The following day however staff noted "*There is no evidence of psychosis*" and aripiprazole was stopped due to unpleasant side effects.

5.209 In July Mr P told staff that he had addressed his post-traumatic stress disorder symptoms at Broadmoor and that he had done all of the psychological work that he needed to. Staff noted "*recent relapse in symptoms of paranoia, voices and intrusive thoughts … demanding behaviour of repeatedly asking for things from different members of staff … no objective evidence to suggest that he is in severe pain as he claims*". However, Mr P reported that the self-harm and violent thoughts had stopped since starting on clozapine and that he would prefer to continue to experience the negative side effects rather than stop clozapine. (It appears that Mr P did not properly understand some clinical decisions, because staff had noted that the negative side effects were associated with aripiprazole, not clozapine.) Mr P had a low threshold of tolerance when having to wait for his needs to be met and walked out of a ward round when he was asked why he wanted to withdraw £50. Staff noted that he had "*a poor memory and difficulty organising things*" when on community leave.

5.210 In August Mr P reported that he had taken an overdose of six lofepramine and had put the rest of his medication (clozapine) down the toilet, after being told his son, aged 16, was involved in drug use. The emergency department doctor noted that Mr P was "*currently under psychiatric hospital for schizophrenia*" yet at this time his recorded diagnosis was not schizophrenia but personality disorder. Mr P expressed a desire to kill another patient (Patient C) and threatened to make a weapon and stab him. He demanded a ward move and to see the unit co-ordinator again (in place of ward staff). Mr P reported that Patient C was backstabbing him by talking about him with other patients. Mr P was transferred to the admission ward but later said that he had requested the ward move because Patient C wanted to rape his children and other family members. Mr P repeated his plan to kill Patient C by strangling him or using boiling water while he was asleep. Mr P constantly

asked to see doctor and said that he saw Patient C bully another patient and claimed the wards had equipment with which he could make a bomb. The dose of clozapine was increased to 175mg at night and venlafaxine was increased to 225mg shortly afterwards.

5.211 On 13 August Mr P tried to enter the room of another patient. Staff mentioned the possibility of leave being postponed because of Mr P's behaviour, to which Mr P responded that he would "*cut up*" if leave to his father was postponed. He later denied having said this.

5.212 In late August Mr P reported that staff had let him down by not supporting him when he was being bullied by Patient C for a long period of time. Mr P was also "*repeatedly telephoning and disturbing his father …*"

5.213 On 1 September Mr P was transferred back to the rehabilitation ward and his responsible clinician was again Dr B3. Dr B3 completed a T2 on 3 September and the clinical entry has no mention of the clozapine being prescribed off licence. A couple of weeks later staff noted "*No evidence of any overt psychotic symptoms*" and after blood testing suggested low clozapine levels, the daily dose of clozapine was increased by 50mg.

5.214 On 5 October staff noted Mr P was "*quite demanding of staff time …making the same requests repeatedly … said that he felt paranoid that nobody wanted to talk to him …*". Mr P visited his father on 14 October and on 18 October escorted community leave was reinstated and Mr P complained that staff treated him "*like a baby*" and became visibly agitated when his demands were not met.

5.215 On 21 October Mr P had a further ward transfer, to a different ward. He told staff "*I have done my time with groups and am not doing any more*". Staff later noted that Mr P would described physical symptoms that "*were not relevant clinically…*"

5.216 In November staff noted that Mr P was asking other patients to use their tobacco rather than his own. A nursing report noted that Mr P's mental state had vastly improved since being back on clozapine. A Care Programme Approach meeting was held on 17 November when it was noted that Mr P "*still no [unescorted community leave]*" and that Mr P had reported that the clozapine was helpful because he felt less bothered by people and that his fantasies about killing people changed when he started taking clozapine. No paranoia or hallucinations were noted. Medications were valproate 2,400mg, venlafaxine 225mg, clozapine 250mg daily. Staff noted that a move to St Ann's Hospital was "clearly" the next step.

5.217 Shadowed leave (unescorted community leave with staff following Mr P or watching him covertly) was introduced on 29 December.

2011 – Ravenswood House and St Ann's Hospital

5.218 In January Mr P reported thoughts of anger and property destruction, prior to a tongue biopsy. Mr P was granted unescorted community leave but sometimes he would be followed, potentially covertly.

5.219 On 1 February a junior doctor noted that Mr P "*has been seen frequently, almost every day for brief chat, he requests to see doctor and usually about pain, tiredness, mouth ulcer pain, sweating, hot and cold feeling … most of the time he has been on and off codeine-based painkiller*".

5.220 On 7 February Mr P's care and treatment was taken over by a new locum consultant forensic psychiatrist, Dr A1. Two days later staff noted "*There are concerns about his frequent request for pain relief. He appears to be unable to manage without pain relief … It is likely that he is dependent on both the medication and the medical contact …*" and that Mr P appeared brittle when his needs were not met immediately.

5.221 On 4 March Mr P made his first visit to St Ann's Hospital, telling staff "*I've done all my therapy*". Shortly afterwards Mr P told staff at Ravenswood House that he wanted to be discharged into the community directly from his current unit, and that he did not want to go to St Ann's Hospital.

5.222 A T2[41] was completed on 16 March but again there was no mention in the notes of the fact that clozapine was being prescribed off licence. On 25 March Mr P complained about not being given morphine for stomach pain (he had been given this when assessed at general hospital the previous day), stating that other patients got opiates for less pain. He told a nurse that he was just like everyone else and that she was not listening to him, and then walked out. Later that night, he reported he had tried to poke a needle into his eye (this was later clarified as his eyebrow) to alleviate the pain, by distraction.

5.223 On 26 March Mr P's unescorted leave was suspended. Mr P said that staff had done nothing about his pain and claimed that doctors at the (general) hospital had told his staff escort that he should be given a strong painkiller if the pain persisted, but that the staff escort had not handed this over to other staff on the ward. He repeated that staff were doing nothing for him. Two days later the dose of clozapine was increased by 50mg, to 300mg daily and his unescorted ground leave was reinstated.

5.224 Mr P's next visit to St Ann's Hospital was on 11 April. He asked to leave early and said he would prefer to wait and go elsewhere. Mr P maintained that he was adamant he was not willing to move to St Ann's Hospital, saying that the hospital was rubbish, there was too much medication, he would be required to complete activities in order to access leave, and that it was a restrictive environment.

[41] *T2 is a form for consent to treatment under the Mental Health Act 1983.*

5.225 A case conference on 20 April noted that Mr P was making steady progress and that he was hesitant about St Ann's Hospital because of his past experiences there. He believed that being transferred to St Ann's Hospital would be detrimental to his mental state and felt that he did not need to be in hospital. Mr P was using unescorted community leave and it was again noted that clozapine had been increased by 50 mg (to 300 mg). Staff noted numerous instances of Mr P making physical complaints, and "*believing he had not been listened to as he had not been prescribed strong painkillers*". Staff noted that he could be irritable, impulsive, impatient, abrupt and rude. Medication was clozapine 300mg, valproate 2400mg, and venlafaxine 225mg.

5.226 Between 20 April and 4 May Mr P's leave was suspended. It was reported he was unhappy about a member of staff and said that his consultant was making a judgement about him having known him for only one month. Mr P wanted to change team, primary nurse and responsible clinician (consultant), and refused to visit St Ann's Hospital again. Mr P said that other patients got medication for anxiety on request, but he did not and that no-one was listening to him. He later said he would accept a move to St Ann's Hospital, having discussed this with father. Ground leave was reinstated on 26 April and community leave reinstated on 4 May.

5.227 In May Mr P told staff he felt he could cope independently in the community, and no longer required hospital treatment. He asked the social worker to contact his son, Mr Z2. Mr P had not seen him for ten years and had no knowledge of his whereabouts. Dr A1 noted that Mr P had negative attitudes towards child sex offenders stating, "*My opinion is that he does have a personality disorder...".* Staff noted no major management problems in previous six months and that Mr P was using unescorted community leave.

5.228 In May a junior doctor updated the case summary document, the sixth such edition since this document was created in June 2009. The summary did not mention any plot to kill a patient in (or around) June 2002. It repeated the '*periods unaccounted for*' (gaps) set out in earlier versions and other reports and confirmed that Mr P was hearing voice of "*Hans Blood*" in 1999, 2003 and 2006. The document also stated that "*that diagnosis [mixed personality disorder] had been unchanged since 1990*", hence overlooking the fact that a diagnosis of schizophrenia had been made at Broadmoor. This diagnosis was made no later than April 2006 and was maintained up to his discharge from Broadmoor in March 2009. This document was passed on to Dorset Forensic team and "*formed the basis of subsequent medical reports"* prepared by that team according to the Trust's own internal investigation. A nursing report noted Mr P had fluctuating mood and was preoccupied with his physical health.

5.229 On 10 May Mr P's Section 37 was renewed, citing a diagnosis of mixed personality disorder (emotionally unstable and dissocial traits).

5.230 On 17 May Mr P visited his father and on 20 May Mr P asked his solicitor to challenge the St Ann's Hospital pathway.

5.231 In June staff again noted that Mr P could "*become easily frustrated and when disappointed, angry … will acknowledge his emotional state can be reflected through his physical complaints*".

5.232 A MAPPA[42] meeting was held on 23 June when Mr P was recorded as a Level 1[43] case.

5.233 Despite his earlier protestations, in July Mr P told staff he was willing to move to St Ann's Hospital. Staff noted he was using unescorted community leave at that time and during a recent three-day omission or re-titration of clozapine (due to incidental non-supply), he experienced thoughts of harming himself and others.

5.234 A later nursing report (dated 16 September) stated Mr P had "*racing thoughts wanting to harm himself and others, had visions of hanging himself, tactile hallucinations, restlessness and inability to sleep*".

5.235 On 26 July a Tribunal was held when it was noted that Mr P "*is not at all keen to go to [St Ann's Hospital] … as he fears he will be attacked by some drug dealers … does not believe [further hospitalisation] is necessary, and would prefer not to …there was no prospect of the funding authority in Dorset approving a placement outside the Dorset area…*". The multi-disciplinary team expressed surprise at learning that Mr P was contesting his transfer at that time. The social work report to the Tribunal noted no recent contact with either of Mr P's sons and also stated that the April 2002 assault "*precipitated*" the transfer to high secure hospital, eight months later.

5.236 Between 26 August and 3 September Mr P was admitted to general hospital with an infection that exacerbated his asthma. The dose of clozapine was reduced to 225mg (from 300mg).

5.237 A Care Programme Approach meeting was held on 21 September. Dr E1 and Mr N1 from the Dorset forensic team attended. All reports associated with this meeting were loaded onto the Dorset electronic patient record. It was reported that Mr P was still resentful of St Ann's Hospital, due to improper treatment previously. Staff described Mr P as a "*sociable person who spends most of his time with his peers … engagement is pleasant*". It was noted that Mr P had recently tried to borrow money from other patients and that he had received no visitors whilst at Ravenswood House. There had been two administrative interruptions in clozapine (including three days in early July where he had none at all), but medication at that time was clozapine 225mg (reduced after his admission to general hospital the previous month, because he had stopped smoking), valproate 2400mg, venlafaxine 225mg daily.

5.238 On 30 September Mr P visited St Ann's Hospital.

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[42] *Multi Agency Public Protection arrangements.*

[43] *Level 1 is the least complex MAPPA category. It indicates that a case can be managed by the organisation responsible for the supervision or case management of the individual.*

5.239 By mid-October Dr B3 was Mr P's responsible clinician again and Mr P had returned to smoking, his clozapine level was recorded as 0.12 and norclozapine at 0.05 (suggesting poor compliance with clozapine in the preceding days).

5.240 Plans were made to transfer Mr P to St Ann's Hospital in early 2012 and a discharge summary prepared at the end of 2011 confirmed Mr P's final diagnosis of mixed personality disorder (predominantly dissocial and emotionally unstable traits) and multiple drug use. At the time Mr P was "*severely obese*", with a BMI of 42, he was hypertensive and had COPD and asthma. The summary noted Mr P had "*often described hearing the voice of a man named 'Hans Blood' … but it is also clear that he is prone to acting out…*". The discharge summary does not mention why (or when) mental illness was diagnosed, or why (or when) clozapine was prescribed, all that is noted in relation to clozapine was that the dose was 275mg daily, with an intention to increase it to 300mg daily. The discharge summary does not mention any plot to kill in 2002.

2012 – St Ann's Hospital and discharge to the community on a community treatment order

5.241 In January 2012 Mr P was admitted to St Ann's Hospital. At the time he said that he had no knowledge of his son Mr Z5 and told staff that he was admitted to a high secure hospital because he had stabbed a paedophile in the eye. He was clear that he wanted to re-locate to Cornwall (to live near Mr Z2) and made several complaints of staff not allocating time to him, saying that no-one cared. Mr P was having frequent (often daily) contact with his son Mr Z2 and often spoke to his former partner (Mr Z2's mother). Mr P told staff that "*he used to carry illicit substances all over the country and this was giving him huge profits (£5,000 per week) … participated in a riot at prison … used to burn cars … committed fraud against his bank*". Mr P told staff that his son's mother suffered from agoraphobia and that his son was her main carer, and consequently his son was not able to visit Mr P on the ward.

5.242 On 9 January blood testing confirmed Mr P's clozapine levels were just below the generally accepted therapeutic range (at 0.34).

5.243 At a ward round meeting on 30 January Mr P's primary and secondary diagnoses were noted as paranoid schizophrenia and dissocial personality disorder respectively. This was documented in handwriting on a ward round template or form, and it is not possible to tell who completed this document. Similarly, there is no recorded account of why a primary diagnosis of schizophrenia was recorded, as this diagnosis had not been made since around March 2009.

5.244 In February Mr P told staff "*It's time I was discharged. All I did was threaten somebody*". Mr P's father told staff that he hoped his son could be discharged back to his (Mr P's) former partner's house in Bude, Cornwall *"…so he could live with her and his son*". Staff noted that Mr P appeared to have a "*somewhat idealistic view*" about resuming relationships with son and ex-partner. Mr P confirmed his wish to ultimately live with his former partner and

their son. Mr P was encouraged to attend groups but was reluctant to do so. He told staff that he felt suicidal because he had been told to attend groups. Staff noted that he was argumentative during a group session and "*…alleged that staff … are out of touch with the patients and do not understand how they feel … also an obvious attempt … to rally other patients in order to criticize staff and the ward routine*". Staff also noted that Mr P did not understand why he had to be on a forensic ward and complained that he had not been offered any one-to-one time for many days. However, there was evidence that Mr P had been offered these sessions but had declined them. Dr E1 updated the HCR-20 noting that Mr P had been reclassified as having a mental illness in 2006 but was currently not thought to have a major mental illness. Dr E1's mental health report was much more detailed about what happened at Ravenswood House than the discharge summary was, and it also contains details of the Broadmoor admission (which the former document obviously does not). It gives the impression of someone who has read the records thoroughly. Dr E1 noted that Mr P had "*responded to treatment with antipsychotic medication and has presented, at times, with symptoms consistent with paranoid psychosis. However, at this time it is felt that his primary diagnosis is that of a personality disorder …*". Dr E1 also noted that clozapine was being prescribed off licence to treat personality disorder. It was later noted that Mr P needed to stay on clozapine on a long-term basis.

5.245 In March staff noted longstanding somatising behaviour (somatisation is a tendency to experience and communicate psychological distress in the form of somatic symptoms and to seek medical help for them) and that Mr P's primary nurse and Dr B2, consultant clinical and forensic psychologist, would work on anxiety management and possible post-traumatic stress disorder. It was also noted that discussions with Cornwall would be initiated. Mr P was offered his first psychology session during March, the only session to be offered during this admission to St Ann's Hospital. Dr B2 and Mr N1 later visited Mr P's former partner and their son. Nursing staff noted "*…low grade behaviours demonstrating negative views about treatment plan / ward activities …*". Mr P told staff that when he was able to live in Cornwall he "*would see if a relationship with his ex worked out … 100% sure I'd not be touching drugs again …*", Mr P was also clear he could not drink alcohol again.

5.246 At a Tribunal hearing on 16 March Mr P sought immediate discharge from being detained on section. It was noted that Dr E's "*view was that there is some form of psychotic illness also present, although for the purposes of a formal diagnosis … today [she] relied upon the diagnosis of psychopathic disorder*".

5.247 A Care Programme Approach meeting nearly two weeks later noted that Mr P "*has presented at times with symptoms consistent with paranoid psychosis … primary diagnosis [is] personality disorder … clozapine … benefits some of the features of [personality disorder]*". The Care Programme Approach report noted that Mr P evoked "*…splitting and countertransference within the nursing team*".

5.248 On 18 April Mr P reported that it was the anniversary of him being raped and that he was experiencing flashbacks of seeing his neighbour's face laughing at him.

5.249 On 26 April Mr P's father died after a short illness. Not long afterwards Mr P said he was feeling aggressive.

5.250 On 10 May Mr P "*talked about being raped at the age of 12 by a neighbour*". The following day he attended his father's funeral and told staff that his sister had not acknowledged him there. He said he intended in future to focus on people who valued him. A week later a patient turned up with duty free tobacco, stating Mr P had asked her to get this for him.

5.251 Also during May Mr P was prescribed metformin to improve his metabolic profile and forensic team staff requested disclosure of Mr P's convictions from the police. Towards the end of the month a community mental health nurse made a referral to the supporting people hub at Bournemouth Borough Council, a central hub dealing with all referrals into supported housing.

5.252 During June Mr P made numerous complaints about his physical health and expressed frustration at being in hospital. He told staff all that he was working for was to see his son. Mr P's responsible clinician indicated they felt that Mr P he was ready for a Community Treatment Order although Mr P appeared to underestimate the challenge of living in the community. Mr P talked with staff about his past and the fact that he had not been diagnosed with schizophrenia until he was in a high secure hospital, and that he felt that he would not have been in hospital for as long had this been noticed earlier.

5.253 On 13 June when Mr P's section was renewed it was noted he had a "*longstanding diagnosis of a personality disorder with associated psychotic symptoms*".

5.254 On 29 June Mr P visited his son (Mr Z2), his former partner (Miss Z1) and her partner, for the first time.

5.255 During July it was noted that the plan was to discharge Mr P to the Bournemouth area first. Leven House was identified as a suitable mental health support housing service. Mr P's weight at this time was 125kg.

5.256 On 24 July Mr P's responsible clinician noted his diagnosis as mixed personality disorder, and that Mr P was making good progress. The intention was to discharge Mr P on a Community Treatment Order to supported accommodation.

5.257 On 2 August Mr P visited his son Mr Z2 again and on 6 August Mr P started having overnight leave to Leven House in Bournemouth. A few days later extended leave was noted as being planned.

5.258 At a review by Dr E1 and Mr N1 at Leven House on 4 September, they noted that Mr P "*accepted our view that perhaps he underestimated the need for support*". Mr P's weight then was noted as 127kg and a BMI of 41.

Discharge to the community on a Treatment Order

5.259 However, despite this comment on 5 September Mr P was discharged from St Ann's Hospital to Leven House, on a Community Treatment Order. The discharge summary gave Mr P's diagnosis as "*mixed personality disorder*" and indicated that Mr P was being prescribed clozapine 300mg, described as off licence and apparently significantly beneficial. It was also noted that in late 2011, "*experience of having his thoughts interfered with in the past, as well as hearing second person auditory hallucinations, both inside and outside his head, telling him to harm and kill himself and others … recurring nightmares of being raped …presented with a number of physical symptoms … seeking a lot of reassurance from staff …*".

5.260 Mr P was reviewed by Dr E1 on 19 September and again by Dr E1 and Mr N1 on 26 September. By this time Mr P had already moved to a full self-catering arrangement but it was noted that he had a "*history of somatising and expressing his distress via physical symptoms...*".

5.261 On 2 and 3 October Mr P had an overnight visit to Cornwall to see his son. On 5 October he was reviewed by Mr N1. On 9 October Mr P was reviewed by Dr E1, as part of a Care Programme Approach meeting that was also attended by Mr N1, a community mental health nurse and Dr B2. It was noted that Mr P's son, his mother and her partner lived in an isolated village and that Mr P remained "*preoccupied with his physical health … also complicated by the fact that he somatises at times*".

5.262 On 12 October Mr P reported that he had been told at his Care Programme Approach meeting "*that he was not to keep talking to staff*". He also disclosed that he had been experiencing paranoid thoughts when he was out, believing he was seeing people from his past. Mr P wondered if the dose of clozapine needed to be increased.

5.263 On 14 November Mr P was reviewed by Dr E1 who agreed to initiate a referral to the forensic team in Cornwall and planned a clozapine blood test.

5.264 On 14 December Mr P was reviewed by Dr E1 again. She noted that Mr P was markedly overweight. Mr P "*had had a couple of 'moments' when he described himself as paranoid … there were times when he wondered if he was being sussed out by staff at Leven House to get him back to hospital*".

5.265 Mr P spent six days over Christmas with his former partner and their son. It was reported that they would like him to be able to move down to Cornwall. Mr P's stay in Cornwall was extended because of flood damage to the rail tracks, meaning that no trains were running.

2013 – Community Treatment Order, readmission to St Ann's Hospital, and second discharge to the community on a Treatment Order

5.266 On 2 January Mr P's move to the annex was agreed in principle. This would mean that he had greater independence. A couple of weeks later Mr P made

a formal complaint about inappropriate remarks made by a support worker at Hanhemann House Community Rehabilitation Service, he appeared brittle for several days afterwards. An HCR-20 completed around this time referred to "*a tendency to self dramatisation*", a phrase that is repeated during several versions of that document. On 29 January Mr P started a relationship with a female co-resident, Miss Z7.

5.267 In a referral from Dr E1 to Dr R1, consultant forensic psychiatrist in Cornwall, Dr E1 stated, "*There has always been debate as to whether he has been psychotic or not*". Dr E1's letter requested forensic mental health follow-up for Mr P who wanted to move to Cornwall to live near his son who lived near Bude. Dr E1 reported that Mr P appeared to make "*good progress in particular to psychological treatment*" while at Broadmoor and that since discharge from St Ann's Hospital he had lived in local authority 24-hour supported accommodation prior to recently moving to a more independent annex. Dr E1 noted that Mr P "*clearly gains a lot from the support not only from the staff at Leven House but members of our Community Forensic Team…*". Dr E1 also said that Mr P had "*historically somatised but also had real physical health problems*". Dr E1 advised that there had been two occasions when Mr P was in Broadmoor when clozapine had been stopped, but both times clozapine had been restarted because of a deterioration in Mr P's mental state. Dr E1 was clear that the funding responsibility for Section 117 aftercare sat with Bournemouth Borough Council.

5.268 On 5 February Miss Z7 ended her relationship with Mr P. Two days later staff noted that Mr P attributed the incident with the support worker and the and situation with Miss Z7 to still being in Bournemouth. Staff reported that Mr P was "*very focused on moving back [sic] to Cornwall*".

5.269 A week later staff noted that Mr P's relationship with Miss Z7 had been rekindled.

5.270 On 14 February Ms D2, a forensic community mental health nurse in Cornwall made an entry noting the referral from Dr E1. Ms D2 indicated she would review the large amount of referral information and discuss it with the team before responding to Dr E1. Ms D2 noted that her initial view was that care co-ordination would not be appropriate from the forensic team because Mr P was on a community treatment order, not a restriction order. This would mean that in Cornwall Mr P would have a responsible clinician based in a community mental health team rather than the forensic team.

5.271 The following day Miss Z7 disclosed to staff that Mr P suffered from incontinence during nightmares. Ms D2 noted a telephone conversation with Dr E1, stating Mr P could be "*quite rigid in his thinking and be black and white in his views … He can find effective problem solving quite a challenge*".

5.272 Mr P was reviewed by Dr E1 who noted that he was coping well with the move into the annex where he had less support and supervision. It was also noted that Mr P had a new care co-ordinator Mr K1, forensic community mental health nurse.

5.273 On 19 February Mr P's relationship with Miss Z7 ended again. The following day Mr P asked to be locked up in St Ann's Hospital. He appeared frustrated and negative, and said he felt let down. Staff noted *"longstanding schemas relating to abandonment and rejection*".

5.274 On 22 February Mr P visited his son. During the visit Ms D2 took the opportunity to assess Mr P and noted that the Cornwall team "*could not replicate*" the "*intensity*" of input Mr P was receiving from the Dorset team. Ms D2 indicated that she anticipated being able to offer weekly visits initially, "*therefore [his] mental state would need to be stable at the point of transfer*".

5.275 The Cornwall Partnership NHS Foundation Trust clinical records contain a document completed by Ms D2 that states:

> *"His psychosis is currently stable … has diagnosis of psychosis and personality disorder … is technically being prescribed clozapine off licence as he does not carry a diagnosis of a psychotic illness … [Mr P] and his care team have significant work to do in identifying an appropriate area and housing …"*

5.276 Later that month staff at Leven House reported that Mr P had been: "*constantly complaining about everything and everyone*".

5.277 In March Dr E1 noted that Mr P was impulsive and that marked concrete thinking was still evident. Mr P's Community Treatment Order was renewed on 4 March and three days later staff noted that he was low in mood and was experiencing paranoid thoughts (the occupants of a black car had nodded at him twice; and Leven House staff had been talking about him). Mr P had reportedly stated that he intended to split up his former partner's current relationship and move back in with her and their son stating "*everything had gone wrong since he moved to Bournemouth in the 90s*". Visits from forensic team staff were increased.

5.278 On 18 March Ms D2 said that Mr P would need to move first to supported housing accommodation (in Cornwall), because the Cornwall forensic team could not replicate the level of the support from the Dorset Forensic team (a support worker plus very frequent care co-ordinator visits). Mr P had described "*confusion*" over his diagnosis, and "*is clearly highly driven to move to Cornwall as soon as possible*".

5.279 On 21 March Mr N1 and Mr K1 informed of the views of Cornwall staff noting "*It could take some time to organize his transfer as the team … would need to be assured that he could cope in the community and funding would have to be secured through Bournemouth LA [local authority] and the NHS … to pay for out of area accommodation*". Mr P subsequently took amphetamine although this was not disclosed until the following day when he confessed to staff who had immediately discharged Mr P from Leven House. It appears that Mr P later indicated that he knew that this action would lead to him being removed from Leven House and that this was the least damaging option that would result in him being re-admitted to hospital.

5.280 On 24 March, under the provisions of his Community Treatment Order, Mr P was recalled to hospital by Dr S1 who stated: "*You have taken amphetamine and are going to be homeless as a result*". Dr S1 made an entry into Mr P's records indicating that the decision to recall Mr P was because of "*his amphetamine misuse and his homeless state*". Mr P was admitted to Twynham Ward, St Ann's Hospital. The discharge summary from Leven House notes:

> *"The staff [at Leven House] and also [the DFT] had noticed a change in [his] mental state in the few weeks prior … Given his significant risk history, largely that of violent behaviour towards other people he was recalled … for a period of assessment and treatment".*

5.281 The Trust's internal report author has noted that "*in the lead up to his recall Mr P had been reporting what appears to be me to be paranoid experiences possibly indicative of psychosis. These were of a persecutory nature…*"

5.282 Dorset staff informed Ms D2 in Cornwall that Mr P had been recalled to hospital. Ms D2 said that she would close the referral to Cornwall services.

5.283 Mr P blamed staff for the failure of his placement and was not able to accept responsibility. "*You are all the same … it's always my fault*".

5.284 After admission, testing showed lower than expected clozapine and valproate levels.

5.285 A ward round form completed on 2 April indicated that Mr P's diagnosis was "*schizophrenia and mixed personality disorder*". This diagnosis appears again on an equivalent form completed on 1 October 2013. It was noted that Mr P had made occasional threats of violence to other patients but was not psychotic. Staff also noted that Mr P hoped to be discharged at the Tribunal and then move to live near his son.

5.286 Throughout April Mr P continued to blame staff for the fact that he had been recalled to hospital and that the staff had let him and his son down because they did not help him. He later denied that he had been rude to staff and that staff had not been listening to him. This resulted in unescorted ground leave being withdrawn. Mr P told staff that he was being punished, and that this was the reason that he was not being discharged to Cornwall. Mr P's son, Mr Z2, who was now noted as his Nearest Relative, did not think Mr P needed 24 hour supported accommodation. Staff continued to consider that Mr P regarded his relationship with his son as idealised and noted that Mr P was "*Unable to adapt his thinking at all, and states he has decided to just give up".* A report by Mr P's responsible clinician noted his diagnosis as mixed personality disorder, stating "*there have been queries as to whether he may in addition be suffering from a psychotic illness*". While an unsigned ward round note on 23 April recorded Mr P's primary diagnosis as schizophrenia, a Tribunal report prepared by Mr P's responsible clinician on the same date named mixed personality disorder as the primary diagnosis.

5.287 In May Mr P's prescription of valproate was changed to liquid. A urine drug screen returned positive for amphetamine that led to unescorted leave being suspended. Mr P denied any drug use and claimed another patient had tipped something into his drink. A later urine drug screen was clear but staff noted that Mr P continued "*to appraise most situations in a pessimistic and unhelpful manner characterized by catastrophizing, concrete thinking and at times externalizing any responsibility*". However, staff noted they felt that Mr P was taking some responsibility so unescorted garden leave and escorted community leave was reinstated enabling Mr P to visit his former partner and their son at the end of the month.

5.288 At the beginning of June Mr P threatened to break the arms of another patient who picked up his drink, staff described him as "*highly agitated*". The plan was for Dr B2 to complete a psychology assessment for the Pathfinder service[44]. Mr P had been referred to the Pathfinder service and was considered as a new referral. On 12 June Mr P complained of feeling physically unwell and the following day collapsed and was admitted to the general hospital. He was diagnosed as having septic shock necessitating him to be placed in an induced coma in the intensive therapy unit. It appeared he was suffering from severe pneumonia. Mr P returned to St Ann's Hospital on 25 June when it was noted that he had stopped smoking and had lost a significant amount of weight (14kg) weighing 100kg.

5.289 A nursing report completed on 7 July noted Mr P had maladaptive coping, he focused on past events, and had a catastrophising tendency, all of which were considered to be consistent with personality disorder.

5.290 Mr P made a visit to his son in Cornwall on 14 July and repeatedly stated he wanted to be discharged to Cornwall to live near son.

5.291 On 19 July it was noted that Dr B2 had started a formal personality assessment but the results are not available and were apparently not fed back. During July Mr P was again referred to the Supporting People hub in order to secure housing.

5.292 A Care Programme Approach meeting on 26 July noted that Mr P had two voluntary jobs and that the plan was to discharge him with a Community Treatment Order under the care of 'Pathfinder' service (personality disorder service).

5.293 In August Mr P was seen by psychology staff (Dr B2 and Ms C2, assistant psychologist) to complete the IPDE. Mr P continued his voluntary work and had unescorted overnight leave to see his son in Cornwall. During one of his appointments with Ms C2 Mr P told her that he would not have any future relationships with other patients because of his experience with Miss Z7. Ms C2 noted that Mr P appeared to "*lack insight into potential triggers for relapse … specifically interpersonal difficulties*".

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[44] The Pathfinder service is a community based service for forensic patients, diagnosed with a personality disorder, who are at risk of offending

5.294 In September Mr P was offered a housing placement but concerns about risk were mentioned and this led to the offer being withdrawn. On 17 September Dr E1 wrote to Ms D2 advising her that Dr S1 would become Mr P's responsible clinician on discharge from hospital. Dr E1 asked for an appointment with Dr R1 to further Mr P's goal of moving to Cornwall, although it was noted that the plan would be for initial discharge to the Bournemouth area with support from the newly developed Pathfinder Team. The letter states:

> *"We are aware that there are a number of practical issues, as the Borough of Bournemouth having [sic] Section 117 aftercare responsibilities … [Mr P] himself does not see himself as constrained by these technicalities…"*

5.295 More meetings with Dr B2 and Ms C2 took place during August and at the Pathfinder review meeting it was noted that Mr P "*continued to complain of various physical health problems, including knee pain and back pain*".

5.296 Mr P had unescorted leave in Cornwall between 30 September and 3 October.

5.297 On 3 October Dr R1 wrote to Dr E1, offering to meet Mr P. Dr R1 advised "*We would be able to support you in obtaining an appropriate community placement … it would be up to his current care team to obtain and finalise this placement… I have not currently opened this as an official referral ...*"

5.298 A scan result showed no cause for Mr P's sciatica type symptoms.

5.299 At a meeting with Ms C2 on 16 October Mr P told her he had kept and illegally driven a car for three months (until he was caught) at Ravenswood.

5.300 During October Mr P was accepted by Northover Court in Bournemouth, a mental health support housing service with 24-hour supported accommodation. He was to share a two-bedroom flat.

5.301 A Section 117 aftercare meeting was held on 22 October and attended by Dr E1 and Dr S1. It was noted that the Pathfinder service would continue to provide psychology support, plus weekly contact with the forensic team. It was also noted that Dr S1 was then Mr P's responsible clinician.

5.302 At an appointment with Ms C2 on 23 October Mr P reported that his son was on the housing waiting list for a flat in Launceston, 12 miles away from where he was living at the time.

5.303 On 28 October Mr P went on extended leave to Northover Court. A social circumstances report completed by Mr N1 on 30 October recognised relapse risk factors as non-compliance, non-engagement, social stress, substance misuse, and poor physical health. Dr E1's report stated mixed personality disorder was of the nature required to justify continuation of the Community Treatment Order due to impulsivity, concrete thinking, limited insight, and vulnerability to stressors leading to risk to self and others.

5.304 Between 1 and 5 November Mr P went to Cornwall on leave and was seen on his return to Dorset by two community mental health nurses. Mr P also saw Ms C2 when he reported that although his son had a new flat in Launceston, Mr P still wanted to live in Bude (a 30-minute drive from Launceston) on moving to Cornwall.

5.305 Mr P was seen by Mr N1, Ms C2 and Mr K1 a number of times during November. He reported that he wanted to have his own accommodation when he moved to Cornwall and expressed some anxiety about changing jobs and have a new manager who would "*boss me about and I'm not standing for it*".

5.306 A discharge planning meeting held on 26 November noted Mr P was at risk of emotional dysregulation if his (idealised) family relationships became difficult. A Community Treatment Order was enacted on the basis of personality disorder with emotionally unstable and dissocial traits, but the form completed by Dr S1 on this date also notes "*he has a history of psychotic symptoms… both disorders have responded to clozapine*". This is the first of two formal documents completed by Dr S1 in which he notes a history of psychotic symptoms, and that these symptoms responded to clozapine. Medication on discharge was clozapine 300mg, valproate 2400mg and venlafaxine 225mg daily.

5.307 A discharge summary prepared by a junior doctor on 29 November included a description of Mr P "*often*" reporting hearing the voice of "Hans Blood", followed by "*but it is also clear that he is prone to using this type of behaviour to cope when stressed*". It was noted that Mr P had specifically expressed violent thoughts towards child sex offenders and that Mr P remained "*vulnerable to stressors triggering impulsive thoughts and subsequently acts that may put himself and others at risk*".

5.308 Mr P saw Ms C2 a number of times during December. It was noted that he found it hard to contemplate future difficulties and that he remained annoyed at being let down by staff and that staff made a mistake at Ravenswood. Mr P was on the verge of tears. Mr P also reported that he had become psychotic when clozapine had been omitted for five days whilst he was at Ravenswood.

5.309 Mr P also saw Mr K1 a number of times during December. Mr K1 noted that Mr P appeared angry and frustrated.

5.310 Mr P had a period of extended leave to Cornwall from 21 December and during this time he saw Dr R1. Mr P told Dr R1 that he had diagnoses of schizophrenia and personality disorder. At that time the plan was for Dr R1 to be Mr P's responsible clinician if he obtained accommodation in Cornwall and Dr R1 asked the care coordinator to contact the Cornwall forensic team social worker. The referral to Cornwall services was put on hold ("*postponed*") until accommodation had been identified and secured by the Dorset forensic team and Dr R1 asked for as much background history as possible.

2014 – Community Treatment Order

5.311 On 2 January Mr P returned to Dorset.

5.312 During January Mr K1 made a number of home visits to Mr P. Mr P appeared to have lost weight and it seems that he had been supporting another resident (Miss Z8). Towards the end of January, a urine drug screen for Mr P tested positive for amphetamines and there are references to "*[Miss Z8's] boyfriend*". Mr P denied using drugs and Mr K1 noted that there were no other concerns.

5.313 On 9 and 23 January Mr P attended a Pathfinder peer supervision group. Throughout January he attended a number of appointments with Ms C2, at one of these appointments there was a further reference to Miss Z8. At the end of January Ms C2 noted that Mr P was worried about being recalled to hospital and appeared slightly paranoid. Mr P also saw an occupational therapist on 17 January.

5.314 At a Care Programme Approach meeting on 5 February Dr S1 saw Mr P who again denied drug use. It was noted that Mr P was starting to engage with services in Cornwall and the Pathfinders service in Dorset. Further leave to Cornwall was planned for 22 to 27 February. Mr P's diagnosis was recorded as mixed personality disorder and medication was clozapine 300mg, valproate 1200mg and venlafaxine 225mg.

5.315 During February Mr P was seen by Ms C2 on four occasions. At one meeting Ms C2 noted that Mr P was unhappy at the references to poor budgeting in Care Programme Approach meeting and being told how to spend his money. Mr P did not co-operate with discussions about this issue. Mr P was also seen on two occasions at home by Mr K1.

5.316 A scan confirmed that Mr P had torn his left anterior cruciate ligament and lateral meniscus (knee ligament and a fluid sac that surrounds the joint).

5.317 At a Pathfinder supervision group, it was noted the Mr P remained very keen to go to Cornwall. However, on 24 February Mr P was unable to go to Cornwall because his son's car had broken down.

5.318 Ms C2 saw Mr P on 10 March when Miss Z8 was present at the start of the appointment. When Mr P saw Ms C2 again the following week Mr P told Ms C2 that Miss B had stayed overnight in his flat, but that the relationship was not intimate. He had however invited her to go to Cornwall with him.

5.319 On 18 March Mr P was seen handing money to a man in a car, and then putting something in his pocket. The following day Ms C2 visited Mr P at home and during the meeting she advised him not to take Miss B with him when he went to Cornwall. On 20 March a urine drug screen was taken, and it appears it was negative.

5.320 On 21 March Mr K1 saw Mr P who said that he had been purchasing black market tobacco. Urine drug screens were done again on 24 and 26 March, both of which were negative. Mr K1 saw Mr P again on 26 March when he

reported that Mr P was doing well as a volunteer at a charity shop. Later that day it seems that Mr P was seen in the emergency department after collapsing. The clinician noted that he had discussed Mr P's case with the mental health team and that Mr P's diagnoses were "*borderline personality disorder, schizophrenia…"*. This episode is not referred to in the Trust notes.

5.321 Mr P was seen again by Ms C2 on 28 and 31 March.

5.322 At a Pathfinder peer review group meeting on 8 April it was noted that Mr P was going to be offered some therapy to deal with relationships and that Mr N1 would support Mr P's transfer to Cornwall towards the end of year. It was also noted that Mr K would consider disclosing Mr P's risk information to Miss Z8 because she and Mr P were spending a lot of time together.

5.323 Two days later Mr K1 met with Mr P who disclosed that he was in an intimate relationship with Miss Z8. Mr K1 noted "*As usual [Mr P] was minimising the issues*".

5.324 On 11 April Mr P saw Dr S1 and Ms C2. Mr P referred to the fact that he was older than Miss Z8's mother. Mr P was seen by Ms C2 and Mr K1 a number of times during April. At a Pathfinder review group it was noted that Mr P had rent arrears. Towards the end of the month Miss Z8's care coordinator expressed concern about "*another*" relationship with "*a forensic patient*". When Mr P saw his GP asking for codeine in place of co-codamol, the GP noted that Mr P "*denies any [history of] drug dependence*". On 26 April Mr P collapsed in his bathroom (we believe this was linked to Mr P's back pain) and on 29 April Mr P was seen by Dr J5, clinical psychologist and Ms C2. Weekly appointments were planned and Mr P's "*longstanding distrust of others*" was noted.

5.325 On 30 April Mr P's GP prescribed tramadol[45] for his back pain.

5.326 At a session with Dr J5 on 7 May Mr P said that he "*did not feel he could trust anyone*".

5.327 Ms C2 and Mr N1 visited Mr P at home on 14 May. Mr P said that the Community Treatment Order did not affect his life and that he would not move to Cornwall before he had cleared his debt with Northover Court and the planned surgery on his knee had taken place. Staff noted that Mr P lacked insight into how any breakdown in his relationship with Miss Z8, or difficulties in the planned move to Cornwall might affect him. A urine drug screen was negative.

5.328 On 23 May Mr P was seen by Dr J5, Dr S1, Mr N1 and Ms C2. Mr P's Community Treatment Order was renewed, and it was noted that he "*remained vulnerable to poor decision making*", at risk of disengagement and at risk of moving to Cornwall without proper planning. Two days later Ms C2 saw Mr P again who said that he was reluctant to do more psychological work and "*mentioned that his memory is quite poor recently*". Ms C2 noted that

[45] *Tramadol is used to treat moderate to severe pain.*

Mr P planned to invite Miss Z8 to Cornwall to see his son and former partner. When Mr P saw Dr J5 on 29 May it was noted that Mr P was worried about a hidden agenda to the psychology sessions. Mr K1 saw Mr P at home on 30 May and described Mr P's mental health history in the presence of Miss Z8.

5.329 On 2 June Northover Court staff reported that Mr P had been anxious and argumentative over weekend, which staff linked to Miss Z8 becoming physically unwell. Mr K1 spoke to Mr P on the telephone and Ms C2 saw Mr P noting that he presented as stable. Two days later Mr P told Mr K1 that his son had found a flat in Launceston for him. Mr P gave further assurances that he would clear his rent debt.

5.330 At a psychology session on 6 June with Dr J5, Mr P appeared agitated and worried about completing a questionnaire, fearing that giving a wrong answer might compromise his moving plans, or lead to him being recalled to hospital. It also appeared that Mr P's rent debt was £254 not £100. Three days later Mr K1 and Ms C2 visited and Mr P again expressed his fear of being recalled to hospital, this time because of the double visit. On 11 June during a session with Dr J5 it was noted that Mr P was "*dismissive of any problems that may occur [in relationship] … felt that [it] was and would remain completely fine…*"

5.331 On 16 June Ms D1 from the Cornwall forensic team asked for an update on Mr P from the Dorset forensic team. Four days later the Dorset team sent an incorrect letter to Mr P's son indicating that Mr P's Community Treatment Order had been recalled (he had been returned to hospital) rather than that Mr P's Community Treatment Order had been renewed. Mr K1 later saw Mr P to explain the error to him, however Mr P did make a formal complaint about the mistake.

5.332 At a home visit with Mr K1 on 25 June Mr P remained very focused on moving to Cornwall, and by the end of year. It was noted that Mr P was taking co-codamol, codeine and tramadol.

5.333 The following day Ms C2 saw Mr P when it was noted that he appeared to be the middle man linking a tobacco supplier to other patients.

5.334 At a Pathfinder peer supervision session on 3 July it was agreed that Ms C2 would reduce her visits to fortnightly, and Dr J5 would see Mr P weekly. The following day Mr P's relationship with Miss Z8 ended. It appeared that it was an amicable split although there were different versions of who had actually ended the relationship. Despite this when Mr P was seen by Mr K1 on 9 July it was reported that he was spending a lot of time with Miss Z8. It was noted that Mr P was planning to send money and tobacco to his son. Mr K1 completed a risk summary referring to Mr P hearing the voice of Hans Blood and of violent thoughts against people who have offended against children.

5.335 On 16 July Mr N1 and Mr K1 saw Mr P and noted that he was "*happy to remain on a [community treatment order] … is looking for accommodation in the Bude area*". Mr P had only paid back £70 of his rent debt of more than

£200. The following day Mr K1 confirmed that the services in Cornwall were happy to accept Mr P when he was ready to move, and a property identified.

5.336 However shortly afterwards when Ms C2 saw Mr P he indicated he was considering moving to his own flat in Bournemouth as an interim step prior to moving to Cornwall. It appeared that Mr P continued to have a friendship, rather than an intimate relationship with Miss Z8. Ms C2 noted that Mr P had to pay off his debts regardless of where he was living, but that Mr P was minimising this issue. When Dr J5 next saw Mr P, he was adamant he would not use substances at any point in the future. It seemed that Mr P wanted to move to private tenancy locally to improve his chances of getting a further private tenancy in Cornwall.

5.337 A social circumstances report by Mr N1 dated 24 July noted that Mr P could suffer a relapse without a high level of support. A risk assessment completed the following day again referred to the voice of "*Hans Blood*", and to no formal history of psychosis. There was continuing evidence of Mr P coping poorly with stressors, and of idealising his relationship with his son.

5.338 A manager's report dated 25 July written by Dr S1 noted a history of paranoid psychosis, and that Mr P showed a good response to antipsychotic medication. This is the second time Dr S1 had made this observation about psychotic symptoms and their treatment (see paragraph 5.306 above). (Nevertheless, at interview Dr S1 told us that he had no knowledge of Mr P's historic diagnosis of psychosis). Mr P's primary diagnosis reported here was personality disorder. Dr S1 also noted "*Were [Mr P] to start to disengage from his treatment plan and his lifestyle become more disorganized there would be an increased risk of return to illicit substances and the consequent risks of violence and harm to himself*". A Care Programme Approach meeting held around the same time noted that Mr P was considered to minimise his previous violence at times with staff stating that he had "*a reputation for being dangerous … which in many ways is ego-syntonic. He appears to identify with the 'macho-aggressor'. However he appears to present differently to males and females … potential for him to sabotage his progress through poor problem solving … likely to be quite institutionalized …overly dependent on the relationship with [his son]*". At that time Mr P wanted to move to independent accommodation by September or October.

5.339 On 30 July Mr N1 and Mr K1 visited Mr P at home and told him that his Community Treatment Order would not be renewed in November if he remained stable. They confirmed that the team did not object to him seeking independent living but that he would need to find his own accommodation with minimal support. It was possible he could be discharged from the Pathfinder programme back to the forensic team, meaning that psychology sessions would stop. Mr P said that he did not want to be without mental health support and would be happy to be discharged to a community mental health team in the future. Mr P's debt at this time was £150.

5.340 At a Manager's Hearing on 1 August it was noted that Mr P's Community Treatment Order was due to expire on 25 November. During August staff noted that some of Miss Z8's belonging were in Mr P's room, and Mr P told

staff that he knew why Miss Z8 had ended their relationship, but he was not keen to share this information. Mr P said that he was planning to move to Bournemouth once he had cleared his rent arrears. Staff noted that the idealised relationship with his son was a major motivator for Mr P. At a Pathfinder meeting on 14 August Ms C2 and Mr K1 reported that they had found Mr P to be "*rather ingratiating and sycophantic*". It appeared that Mr P's debt had reduced to £60 and it was agreed that Dr J5's sessions would be reduced from weekly to fortnightly. Mr P underwent planned surgery (as a day case patient) on his knee on 18 August and the following day staff noted that it seemed that his relationship with Miss Z8 had been rekindled (for a second time). At a Pathfinder review meeting it was noted that Ms C2 had been visiting Mr P fortnightly and that this would stop when she left her post the following month. At a session with Dr J5 on 28 August it was noted that Mr P's debt had increased to £100. Mr P stated that he did not need to plan any further for his move "*because he would sort things out when he arrived there … continues to minimise any likelihood of future relapse...*".

5.341 On 2 September Mr P had his final session with Ms C2 who noted that Mr P appeared fearful of being 'marked down' by services, or information being used against him. Mr P denied that he felt this way, saying he just did not understand the point of what was being asked of him. However, Mr P did indicate he felt he did not need any further psychological work, commenting that he had "*no intention of running off to Cornwall*". Mr K1 saw Mr P the following day when he stated that he had given money to his son and that his debt was now £65. Mr P appeared resentful about his former partner's partner being involved in his son (Mr Z2) having bought a "*duff*" car. Mr K1 later noted that Mr P had started looking for accommodation via letting agents. At a Pathfinder review meeting on 11 September staff noted that Mr P "*…appears to be aware of Miss Z8's association with other males*". It was noted that Mr P's debt had increased to £110. At a Forensic team meeting on 16 September it was noted that Mr P no longer had to attend the snooker group (which he liked) which meant that staff could no longer regularly observe him. Mr P later told Mr K that he was having difficulty finding accommodation and asked for some help to apply for housing association properties. Mr P stated that his rent debt had been cleared. Dr S1 saw Mr P on 19 September and noted he appeared to be "*doing very well*". At the end of the month when Mr P saw Dr J5, Mr P stated he wanted to take the transition slowly and it was noted that he continued to lose weight.

5.342 On 1 October Mr K1 noted that Mr P "*Planned to meet … a fellow [forensic team] patient in Westbourne for coffee as he no longer sees him at snooker*". When Mr P met with Dr J5 towards the end of the month Mr P talked about his activity levels having reduced over the previous few months and that he was in no rush to leave Northover Court. Dr J5 noted "*it seems at present he is ambivalent about this*". It was also reported that Mr P was convinced he had developed irritable bowel syndrome. On 30 October at the Pathfinder review group meeting it was noted that Dr J5 had been seeing Mr P fortnightly, but that the plan was to reduce this to monthly.

5.343 At an outpatient appointment with Dr S1 on 7 November Mr P was discharged from the Community Treatment Order. It was noted that this was the first time that Mr P had been an informal patient in 15 years (in fact, including his time in custody, this was the first time Mr P had been an informal patient in the community for nearly 16 years). Mr P appeared "*slimmer*". At the Pathfinder review and peer supervision meeting the possibility of discharging Mr P was discussed, as there was no longer a need for psychological involvement, but concern was expressed about a lack of structured activity. On 10 November Mr P told Dr J5 that he wanted to establish an informal pool group to replace the snooker group that he had to leave. Around the same time "*an informal gathering*" was arranged, "*tea and cake … to mark the end of statutory supervision*". Present were Dr J5, Dr S1, Dr J2, Mr N1 and Mr K1. A letter confirming that Mr P had been discharged from the Community Treatment Order was sent to his Nearest Relative (Mr P's son). On 19 November Mr P told Mr K1 that he planned to go to Cornwall for a couple of weeks over Christmas. Mr P later provided a urine sample to staff to test for drugs after it was reported that he was drifting off to sleep in the lounge (at Northover Court). It was noted that Mr P continued to illegally sell duty free tobacco.

5.344 Mr P did indeed go to Cornwall on 19 December and on 27 December he attended the A&E department in Barnstaple complaining of post-operative knee pain.

2015 – Living in the community in Dorset and then Cornwall

5.345 On 3 January Mr P returned from Cornwall. He was seen by Mr K1 four days later when he reported that he had spent most of his break at his son's accommodation (as distinct from staying with his former partner). Mr P said that he had drunk alcohol for the first time in years and had tried cannabis. A urine drug screen tested positive to cannabis and opioids. At a Pathfinder review meeting on 9 January it was noted that Dr J5 would see Mr P monthly, and that Mr K1 would see him fortnightly. Three days later when Mr P saw Dr J5 the most recent HCR-20 was updated as part of the planned relocation to Cornwall. There is little difference from the HCR-20 completed in July 2014. Regarding diagnosis, the document notes:

> *"No formal history of psychosis … or any other form of mental illness. The voices … have generally been considered to be part of his personality disorder … currently he is not felt to have a major mental illness".*

5.346 The first sentence of the above quote is inaccurate. It was noted that the Pathfinder team planned to discharge Mr P after the Care Programme Approach meeting that month and then transfer him from the Forensic Team caseload to the community mental health team caseload after six months.

5.347 The Care Programme Approach meeting took place on 16 January and Mr P's difficulty in finding accommodation was discussed and it was agreed that Mr N1 and Mr K1 would provide Mr P with some support with this. It was "*noted that [Mr P] regularly seemed to have some physical health problems*". Mr P would be transferred imminently to the forensic team at which point his care coordinator would change to Ms N1 and Mr P would have two more

sessions with Dr J5. Ms N1 replaced Mr K1 as care coordinator on 20 January.

5.348 On 4 March Mr K1 visited Mr P at home after another resident had alleged that Mr P had been sniffing gas, Mr P denied this. In the same conversation he also said that he believed that his son had been charged with driving without a licence, following a collision. The following day Mr P's housing application was registered, this meant that he was then on the Bournemouth Housing Register. Mr P later said that he did not think that he needed supported housing, but it was agreed that Mr P would be referred to the supporting people housing panel. It was noted that Dr S1 "*does not have any concerns regarding [Mr P] moving to Cornwall*".

5.349 Dr S1 reviewed Mr P on 1 April. It was noted that Mr P had continued to lose weight, and he was then down to about 100kg. Dr S1 noted that Mr P was on enhanced Care Programme Approach. There was a discussion about whether Mr P could source independent sector accommodation and it was noted that "*[multi-disciplinary team] have [sic] agreed he can live independently*". A few days later Mr P reported that he was fed up with living at Northover Court and towards the end of the month he reported that he was missing his son. Northover Court staff made a referral for Mr P to access the rent deposit loan scheme, to allow him to move on from their service. Mr P did not take this up and moved out after making his own arrangements.

5.350 On 6 May Northover Court staff reported to Ms N1 that a fellow resident had reported that Mr P had been having regular fainting attacks and had himself told staff he was having chest pains. Mr P went to see his GP and had a chest x-ray. The following day Ms N1 saw Mr P who denied any drug use but said that he did occasionally drink alcohol. Mr P referred to grievances and irritation with Northover Court residents and said that there was a room in a friend's house in Cornwall that he could rent. Ms N1 indicated she would discuss this with Dr S1 and noted that Mr P's situation appeared to be causing some low mood. A urine drug screen was done that later tested positive for amphetamine.

5.351 On 13 May after a Care Programme Approach meeting Dr S1 wrote to Mr P's GP advising that Mr P had "*found himself some accommodation in Cornwall in order to move back to be near his family*". Dr S1 would liaise with the local community mental health team to arrange a transfer of care. During the Care Programme Approach meeting Mr P reported that being at Northover Court was detrimental to him. It was noted that he had lost a significant amount of weight. It was agreed that Mr P could move to the identified flat in Launceston. The meeting notes state:

> *"has found a flat with a room in that he can stay in and this address can be used for correspondence … aiming to leave on [7 Jun] … Address … and name of person renting the room: [details of Mr P's son provided]".*

5.352 The details in the entry clearly indicate that this was Mr P's son, but this fact is not mentioned in the minutes written by Ms N1. A separate entry was made by Dr S1 and in another entry that day Ms N1 stated that Mr P was moving "*to*

be near his son". It was noted that Dr S1 would liaise with Dr R1 in Cornwall and that Mr P was planning to leave on 7 June and had given notice on his accommodation in Dorset.

5.353 On 21 May Dr S1 wrote to Dr R1 enclosing discharge summaries from Ravenswood and St Ann's Hospital, the latest HCR-20, and risk summary. Dr S1 gave Mr P's proposed new address and stated: "*He no longer engages in regular psychological treatment as our perspective is he has now completed his psychological treatment needs*". Dr S1 asked that Dr R1 take over Mr P's care when he moved, planned imminently.

5.354 On 28 May Mr N1 described meeting with Mr P, Ms N1 and Northover Court staff. It was noted that Mr P said he had agreed to stay with "*a friend*", giving the friend's name as "*Mr [son's surname]*". Mr P indicated that he did not wish to keep the Northover Court tenancy on until he had found his own flat and wanted to move to Cornwall on 6 or 7 June. Mr P was worried that the team would try to detain him or prevent him going to Cornwall.

5.355 On 1 June Mr K1 saw Mr P briefly and noted that Mr P planned to move "*to his son's flat temporarily this Sunday until he can secure a rented property*". (This makes it clear that at least one staff member knew he was to live with his son).

5.356 Mr P did indeed move to Cornwall on 7 June and on 11 June Ms N1 recorded that Mr P had moved, and that all information had been handed to Ms D1. It was also noted that Ms D1 had offered Mr P an appointment for 17 June that had been sent to Mr P's temporary address with his son. Prior to Mr P moving to Cornwall, the Dorset forensic team had identified his risk factors:

- lack of accommodation;
- substance misuse;
- medication non-compliance;
- relationship breakdowns.

5.357 Mr P's recognised relapse indicators were also noted, these included:

- paranoia;
- external voices;
- frustration;
- drug abuse;
- making complaints;
- avoiding interaction with staff;
- physical health worries.

5.358 Mr P registered with a GP in Launceston on 12 June.

5.359 On 17 June Ms D1 met with Mr P and noted that he was living with his son and had registered with the council as homeless. It was also noted that Mr P's son was trying to find work and had recently lost his driving licence. Mr P wanted his son to register as his carer, and wanted to know if his son would be eligible for carer's allowance. It was also noted that Mr P was happy to engage with forensic services during the period of transition to Bodmin community mental health team.

5.360 Mr P was due to see Dr R1 on 25 June but he did not attend.

5.361 On 30 June blood testing again revealed rather low clozapine levels.

5.362 A risk summary was completed on 1 July and updated on 8 July by Ms D1. It was noted:

> *"since his move three weeks ago he has denied any thoughts of harm to himself, although he recognises that when he stressed [sic] then he has thoughts of feeling hopeless and that things will not be resolved. He is living with his son …reasonably settled presentation …however with current stressors around finances and accommodation close monitoring is required … has become confused and lost of where he is [sic], he son [sic] supports him when he goes out …currently being seen by Cornwall forensic team with a view to transfer to North CMHT once he is settled, as he is an informal patient …"*

5.363 On 8 July Mr N1 received a call from Ms D1 who advised that Mr P had not been able to find his own accommodation, was staying with his son on the sofa, and Mr P feared that his son would therefore lose his accommodation (due to sharing). Mr P was feeling stressed at how difficult it was to find accommodation and had told Ms D1 that the Dorset staff had advised retaining his tenancy. Because he had not heeded their advice he had "*as such has made himself intentionally homeless*". The concerns about Mr P's compliance with medication had been resolved and Mr N1 stated that while Section 117 aftercare responsibilities remained with Bournemouth, the local authority was unlikely to pay for accommodation in Cornwall "*as he had made himself homeless and did not need supported accommodation at the time he left the [Bournemouth] area*".

5.364 It seems that Mr P was referred to the North Cornwall community mental health team on 27 July.

5.365 On 11 August Ms D1 wrote to Mr P's GP noting that after a time of being seen by Cornwall Community Forensic Team Mr P appeared well, was temporarily living with his son "*and has spent time with his ex-partner in Bude*". Mr P was finding it difficult to find long-term accommodation, and was being supported by the Cornwall housing team. "[Mr P] *will continue to have secondary care mental health services delivered by the North Cornwall ICMHT [integrated community mental health team] based at Banham House [Bodmin]*".

5.366 In late 2015 there were reports that Mr P's other son had died, a later report mentions suicide by hanging.

5.367 By August Mr P had secured his own accommodation about 20 miles away from his son.

January to March 2016 – living in the community in Cornwall, transferred from forensic services to the community mental health team

5.368 On 8 January Mr N1 wrote to Dr R1 asking for an update and hoping to transfer Section 117 aftercare responsibility to Cornwall now that Mr P was ordinarily resident there.

5.369 On 11 January Dr R1's secretary informed Mr N1 that Dr R1 was no longer Mr P's consultant and that Mr N1's letter had been passed to Ms D1.

5.370 In February it transpired that Mr P had allegedly called "*Mike*" (it is unclear who Mike is) the previous week, being threatening and abusive towards him, having been upset because "*Mike*" had not contacted Mr P regarding the death of Mr P's estranged son. Ms D1 noted that Mr P had reported using amphetamines the previous week. Mr P's GP noted that Mr P had been taking two to three grams of amphetamines every day, had not been sleeping and had tried opiates, but they had not helped him. Mr P sought advice from his GP about stopping. Ms D1 wrote to Mr P at his home offering to visit him on 10 March. It appears that Mr P's care coordinator changed around this time.

5.371 On 7 March Ms D1 responded to Mr N1's earlier letter (addressed to Dr R1), stating that before Cornwall would take on Section 117 aftercare responsibility, they would need to see the relevant paperwork from Dorset in order to assess his Section 117 aftercare needs and whether they were still appropriate. Ms D1 wrote "*we would be need to be clear what his needs are and the commissioners would need to consider if they would accept the transfer of funding … we are not accepting the transfer of [Section 117 Mental Health Act] at this stage and it will be considered upon receipt of the [Section 117 Mental Health Act] documentation*".

5.372 On 9 March Mr P called the community mental health team and told staff that he had been beaten up and was unable to cope anymore. Mr P reported that he wanted to end his life and said that he had the means to do so. The plan was for community mental health team staff to arrange a home visit with police in attendance and inform the home treatment team, in case Mr P needed out of hours intervention. It is stated elsewhere that this assault took place in his flat, and that he was living with his son, not in his own accommodation.

5.373 On 15 March Mr N1 wrote to Ms D1 stating that:

- Mr P was not receiving any Section 117 funded services from Bournemouth or Dorset;

- given that he was ordinarily resident in Cornwall he assumed that Ms D1 had a duty to assess his eligibility for 117 services (Care Act 2014).

- Mr P was living in independent accommodation, with community mental health team follow-up only.

5.374 Mr N1 enclosed the most recent care plan (2014) and the original Community Treatment Order report from 2012.

5.375 On 21 March in an episode apparently not known to mental health services but reported back to Mr P's GP, an ambulance was called by bystanders. Mr P was sitting outside hyperventilating and expectorating, complaining of chest pain. Mr P told the ambulance crew "*his actions are his coping mechanism when people aren't listening to him. He is scared of dying as he had severe pneumonia two years ago*". Mr P was taken to his home address, a GP appointment was made, and his son was informed.

5.376 It appears that in late March, (the date is unclear) Mr P returned to Bournemouth, homeless.

April to August 2016 – homeless in the community in Dorset

5.377 On 1 April Mr P's care coordinator in Cornwall formally changed from Ms D1 to Ms P1.

5.378 On 8 April Mr P's clozapine was sent to his GP but Mr P did not collect the medication.

5.379 On 14 April Mr P telephoned the Dorset Forensic Team and spoke to a nurse advising that he was temporarily in Bournemouth until the following Tuesday. He stated that he was without clozapine for the next seven days as he had forgotten to collect it from Launceston medical centre.

5.380 On 21 April Mr P had the required testing for clozapine at the GP surgery.

5.381 On 22 April the GP in Cornwall noted that Mr P had not collected his clozapine medication.

5.382 On 25 April staff at Northover Court telephoned Mr N1 to report that Mr P was sofa surfing there and had said he would not return to Cornwall. Dr S1 later stated that the service became aware of Mr P's presence in the area when Mr N1 had noted him hanging around outside Northover Court. Mr N1 contacted the Cornwall team and spoke to the duty worker who planned to discuss the matter with Mr P's care coordinator, Ms P1, that afternoon. Ms P1 later called Mr N1 and advised that she had never met Mr P because he had missed all of the appointments arranged during the four weeks she was his care coordinator. Ms P1 stated that Mr P's relationship with his son had broken down, and that he was disliked in the area because of borrowing money from other patients and not paying it back.

5.383 Mr N1 saw Mr P at Northover Court and noted he had lost a lot of weight. Mr P said that he wanted to return to Bournemouth, and that living with his son had not helped their relationship (they no longer had regular contact). Mr P reiterated that he was disliked in Cornwall, and had been badly treated whilst living there, including assaults and burglary. Mr P said he had been sofa surfing at Northover Court and Southbourne Road and Mr N1 advised him to speak to staff at the town hall or try local letting agents.

5.384 Mr N1 spoke again to Ms P1 in Cornwall who undertook to make a written referral to the Dorset forensic team (this took some time to arrive). However, Mr N1 questioned whether forensic services were required, given that Mr P had been under the care of a community mental health team whilst in Cornwall.

5.385 On 29 April Mr N1 received information that Mr P was staying at 59 Southbourne Rd with a fellow resident, Patient D (apparently a Christchurch community mental health team patient). It seems that Mr P had told Patient D that he would get his own flat in Bournemouth the following week.

5.386 On 5 May St Mungo's (a homeless charity) contacted Mr N1 to report that Mr P was "*continuously spending a lot of time at Northover Court and staying overnight …. hiding in a tenant's bedroom*", while denying he had been staying overnight. There were concerns he was involved in financial transactions with various tenants and their visitors. Mr N1 forwarded this information to Ms P1 in Cornwall.

5.387 On 17 May a member of staff from the Cornwall team e-mailed a pharmacist working for Dorset Forensic Team regarding a clozapine patient transfer. The Cornwall staff member stated there had always been a question mark regarding Mr P's medication compliance ever since he transferred to Cornwall (as he reported he had excess medication to his community mental health nurse) and stated "*so might have been taking his medication but at a lower dose or sporadically*". Mr P had reportedly contacted his GP to state that he was no longer taking clozapine. Cornwall pharmacy staff were going to tell the Clozapine Patient Monitoring Service that Mr P had stopped taking it, given that the last supply on 8 April had not been collected.

5.388 Ms P1 wrote to Dr S1 advising that Mr P had left Cornwall with a stated intention not to return, and that she believed he was sofa surfing or rough sleeping in Eastbourne. Ms P1 confirmed that she had only ever spoken to him by telephone in the three months he had been on her caseload, noting:

- he had not attended for clozapine monitoring;
- he had not engaged with the care plan;
- he had been de-registered by Launceston medical centre;
- she was discharging him from her caseload.

5.389 On 18 May the Cornwall pharmacy confirmed to Mr N1 that the clozapine from 8 April had not been collected. Shortly after receiving this confirmation Mr N1 replied stating that Mr P "*has not been formally referred to us and we are not currently responsible for him*". This email was copied to Ms P1 and Dr R1 in Cornwall and Dr S1 in Dorset. Cornwall records indicate that Ms P1 ceased being Mr P's care coordinator from this date. Mr P later advised Dorset staff that his son had completely rejected him whilst in Cornwall.

5.390 The following day Mr N1 made a brief entry noting that care coordination responsibility had been "*handed over to [Dr S1]*". It seems that Mr P was now under the care of Dorset Forensic Team on an informal out-patient basis

5.391 On 25 May Northover Court staff called Mr N1 to report that despite being banned from there, Mr P continued to attend the outside of the property and to receive food and drink from residents. He and a "*vulnerable*" female resident (Miss Z8) were reportedly planning to move to a property together. Mr N1 then emailed Dr S1 stating: "*What are we going to do about [Mr P], I think he should be offered an OPA [outpatient appointment] ASAP as he is currently unmedicated*".

5.392 Mr P was seen the following day by Dr S1, Mr N1 and Mr C1, a community mental health nurse. Mr P said that he had received a very poor service and support from the Cornwall team. He stated he had to live with his son for three months, they then fell out and no longer spoke. Mr P stated he eventually got his own accommodation, but it was in a very poor area and he felt unsafe. He also stated he had been attacked and stabbed "*over drug money*". Mr P said that for about the previous six weeks he had been returning to Cornwall to get medication, that he had been regularly taking clozapine (there is no evidence that Mr P was challenged about this given his staff knew that he had not collected his medication, nor that he was challenged about why 'drug money' was an issue). Mr P said that he had a week's worth of clozapine and had been variously staying at Northover Court, Southbourne Road, a bed and breakfast, and sleeping rough. Mr P said that he did not want to go to emergency accommodation, and that he was bottom of the council waiting list. Staff noted no evidence of relapse. When Mr N1 saw Mr P that afternoon, he was more irritable, saying he had no food or money and that no-one wanted to help him. Mr N1 initiated a housing referral and two appointments were arranged for Hope Housing on 31 May and Michael's House on 6 June. Mr N1 secured a food parcel voucher and drove Mr P to the food bank. Mr N1 telephoned the forensic team to say that Mr P needed to be seen the following day and arrangements were made for Mr A3, community mental health nurse, to check Mr P's bloods and for Dr S1 to prescribe clozapine.

5.393 On Friday 27 May Mr A3 saw Mr P who seemed cross that he had been asked to leave Northover Court. Mr P expressed anger towards services "*verbalised some threats in order to gain housing … he would have a place to stay that night, even if this was a police cell*". Mr A3 advised Mr P that he (Mr A3) would be his care coordinator and that Mr P needed to be patient. Blood testing confirmed that clozapine levels were no lower than they had been previously.

5.394 Mr N1 submitted an application form to the supporting people hub, noting that the Section 117 aftercare responsibility rested with Bournemouth Borough Council and Dorset Clinical Commissioning Group.

5.395 Later that day Mr P called Mr N1 and stated that he would harm himself if he was not offered accommodation. This information was passed to Dr S1 who was described as the care coordinator in this entry. Dr S1 recorded (at 16:13 hours) that Mr P was homeless in Bournemouth, under care of Dorset Forensic Team, and that he (Dr S1) was his consultant. He noted "*Given the inconsistencies in his account about medication … he may need to be retitrated. At present however it is not clear that he needs medication at all*". Mr P diagnoses were recorded as mixed personality disorder (predominantly dissocial and emotionally unstable traits) and polysubstance misuse.

5.396 On 31 May Mr P called Mr N1 and said he had been sleeping rough all weekend (it is of note that the previous day had been a bank holiday). Mr N1 later met Mr P for an interview with a housing provider (after Mr P had initially said he would go with just his friend 'Miss Z8'). Mr P told staff that he had been let down by services in Cornwall, who did not provide him with care and treatment, and "*disagreed that he had chosen to move to Cornwall*". Mr P said he was being let down by the system and no-one was helping him. This was the last time that Mr N1 met with Mr P. Mr P later texted Mr A3 stating "*P****** down nice being homeless!!!*". The supporting people hub later confirmed that they had received Mr P's referral from Mr N1 and that Mr P had been placed on the waiting list for a place at Northover Court. Shortly afterwards Dr E1 completed a prescription for seven days' worth of olanzapine 10mg to be taken as required, as it was becoming increasingly clear that Mr P was unlikely to have any clozapine left. Mr P was asking for medication and was truculent and irritable at times.

5.397 At some point during May (the exact date is unclear) Mr P had approached the customer contact centre (housing) at the local authority and was interviewed by a housing officer. Whilst that officer was on the telephone to staff in the forensic team, Mr P left and did not respond to subsequent calls.

5.398 On the morning of 1 June Mr P texted Mr A3 saying "*as I thought no place to live when people say there would be … I have had enough … you have let me down like all the others*". That afternoon Mr A3 went to Northover Court as arranged, but Mr P refused to meet with Mr A3 that afternoon as he was on a bus in Poole going to meet friends.

5.399 Mr A3 saw Mr P the following day. Mr P said he would never stay at a night shelter due to previous bad experiences.

5.400 On Friday 3 June Mr P saw Mr A3 who noted that Mr P had clean clothes and was clean shaven. Mr P again complained about the service he received and refused to register with a GP because they would only dispense medication daily (rather than on a less frequent basis) to homeless people. Mr P initially refused the prescription for olanzapine. Mr P said he would get a bed via the police or crisis team but was told that he would not get a hospital bed because he did not need one. Mr P said that he did not want to talk anymore and

would turn his telephone off, before throwing his telephone into bushes. Mr P then snatched the (olanzapine) prescription, and said he would take an overdose, and left. He retrieved his telephone shortly afterwards. Mr P's blood results later showed that he still had some clozapine left in his bloodstream (TDM 0.23 and 0.12) and therefore 300mg clozapine was prescribed.

5.401 On Saturday 4 June Mr P was arrested at 3:00am on suspicion of being drunk and disorderly. Mr P had been carrying a whiskey bottle while walking in the road. The police took him to A&E in Bournemouth because they were concerned about unspecified (physical) health issues. In the ambulance en-route to A&E Mr P made "*numerous threats and verbal abuse directed at crew … uncooperative*". According to a later A&E report, Mr P had been found "*wandering the streets and acting bizarrely and erratically … shouting and flailing arms*". Mr P was booked in to A&E just after 5:00am and gave his Launceston address to clinical staff who noted "*Denies substance abuse. He is unclear about how much alcohol he had to drink tonight. No other symptoms. Patient states he is just unhappy because he is homeless and wants a place to stay. Has expressed death wishes … states that he is unable to receive medications as he is homeless*". At some point, Mr P claimed he had taken an overdose of risperidone and haloperidol. Mr P was referred to the psychiatric liaison team and the following discussion between the psychiatric liaison team staff and A&E staff concluded that there was no role for a liaison assessment as this would reinforce Mr P's inappropriate behaviour (with intention of getting mental health services support). An A&E clinical entry at 6:15 am states:

> *"Spoke with [a member of staff] Psych Liaison. He is known double cluster personality disorder. Threatens healthcare staff. Spent time in Broadmoor. Has stabbed patient in eye whilst there. Known arsonist. Known to Dorset forensic service. If requires bed, speak to gatekeeper at St Anns".*

5.402 A clinical entry by a psychiatric liaison nurse made at 9:00am includes:

> *"is closely monitored and robustly followed up by [DFT] … entries in recent weeks of stable mental state … declining the temporary accommodation that's been offered. Also, declining to register with GP … appeared to have voiced to professionals that he intends to gain in-patient admission … also appears to have voiced intent to gain admission via police which appears that function [sic] of last night's incident … there is no current role for liaison assessment … this would reinforce [his] inappropriate behaviours …"*

5.403 Another clinical entry made by a different psychiatric liaison nurse at 9:15am states:

> *"D/w ED medic. Well known patient with diagnosis of mixed personality disorder … well known to [Dorset Forensic Team] … seen multiple times by DFT in the previous few weeks including 3 Jun [sic]. Mentally well, no concerns. Recently returned to the local area … currently NFA with no local GP. Refusing temp accommodation offered by DFT / housing.*

Refusing to register with local GP. Appears to be inappropriately trying to access an inpatient admission due to social issues. DFT have documented that this should not be considered unless there is a clear deterioration in mental state …Voiced yesterday that he'd attempt to gain admission via arrest. Not felt appropriate to reinforce behaviours with an assessment at this time. mentally well yesterday with the team that knows him very well. Any risk behaviours are unlikely to be the product of mental illness. Has follow up with [DFT CPN] Monday".

5.404 After leaving A&E, Mr P was booked back into police custody, where he said he had schizophrenia and was going to kill himself. A criminal justice liaison nurse spoke to the custody sergeant, noting that he was seeking accommodation and had been arrested, as he implied he would be. Police were advised that the "*correct diagnosis*" was mixed personality disorder, and not schizophrenia. The nurse said she agreed with the liaison nurse that assessing him in custody would "*reinforce his accommodation seeking behaviour and it was thought that he would be likely to request a mental health bed on the grounds of self-harm*". The nurse further noted that there was no evidence of deterioration since the previous day's assessment. Mr P was released from custody without a mental health assessment.

5.405 A later entry made by another nurse states Mr P was "*mistakenly brought back into custody … stated that he has schizophrenia and is going to kill himself … police given correct diagnosis … to assess [him] in custody will reinforce his behaviour in seeking accommodation …*"

5.406 On Monday 6 June Mr P was assessed by Mr A3 who noted that Mr P was clean and well kempt. Mr P stated he felt wronged by the police and said that he had not been drunk but that he did have schizophrenia. Mr P reiterated that no-one was helping him, he was neglected by services, and had no support. Mr A3 noted that Mr P was again refusing the emergency accommodation being offered and was not registered with GP.

5.407 On 8 June, at the request of Mr A3, Westbourne Medical Centre agreed to register Mr P as temporary patient. When Mr P was told of this he stated that forensic team staff were providing no support and were not to be trusted. Mr P later wrote a letter (on notepaper headed "*[the name of a doctor] PhD independent psychologist*") stating that he was taking clozapine for an illness "*that they now say I don't have*". Mr P stated he was thoroughly disgusted with his treatment from Dr S1, Ms C3, Mr A3, and Mr N1; all he wanted was somewhere to live; and he wanted someone to help him. "*How can I trust care in the community when there clearly isn't any*".

5.408 Ms B4, social worker in the forensic team, contacted Mr P to take him to Michaels' House, but he declined to go. Mr P again complained about the lack of help from clinical staff and police brutality.

5.409 On 9 June Ms B4 helped Mr P to register with a GP. Mr P said he only returned to Bournemouth because of the only human who cared about him (and vice versa), Miss Z8.

5.410 The following day Mr P was assessed by Mr A3 who also took Mr P to see the GP. Mr P referred to sleeping on benches but despite this Mr A3 noted the "*Conversation all very normal*".

5.411 Mr A3 made telephone contact with Mr P on 14 June and 16 June.

5.412 On Friday 17 June Mr A3 again called Mr P. Mr A3 noted he had telephoned Mr P three times that week and had not been able to meet up with him. "*Each time [he] reports all is good … has all his medication … no thoughts to harm self or others. No demands …unable to say where he is living … in staff location*".

5.413 On 21 June Mr P did not attend an arranged community visit with Mr A3. Mr P told Mr A3 (on the telephone) that he was in Poole and asked to meet on Thursday. Mr P was discussed in forensic team meeting when it was noted that Mr A3 was "*struggling to meet him. Refused to attend to identify possible accommodation. [Dr J2] concerned about formulating his risks and the need for comprehensive risk plans to be reviewed. CPA to be arranged.*"

5.414 On 23 June Mr P was assessed by Mr A3 in the town centre. Mr A3 noted that Mr P was very tidy, appeared to be wearing new clean clothes, was clean shaven, and in bright good humour. Despite his appearance, Mr P said he was using cannabis and sofa surfing locally.

5.415 On Monday 27 June Mr P was assessed by Mr A3 who noted that Mr P had raised no concerns and had appeared "*Warm and reflective … he always felt happy in Dorset*". Around this time Ms C9, social worker, moved to the Bournemouth social care team and Mr P was added to her caseload.

5.416 On 29 June Mr P was seen by Dr S1 who noted that Mr P was well mentally and "*much more relaxed*" than in the past. Incidentally a member of staff from the Poole community mental health team had unknowingly encountered Mr P at Mr Merna's home. Mr P answered the door to report that Mr Merna was not in.

5.417 On Monday 4 July Mr P attended the clozapine clinic.

5.418 On 7 July Mr A3 telephoned Mr P who reported he had been unwell with diarrhoea and vomiting.

5.419 On Friday 8 July when Mr A3 called Mr P he sounded better, Mr A3 noted that Mr P "*reports all is good regarding his mental health*".

5.420 On 12 July (a Tuesday) Mr P was assessed by Mr A3 who noted that Mr P had started to look "*a little unkempt … struggling to find people to let him sofa surf … struggling with his money … talked again about getting arrested so he can have a place to stay … prison was no big deal … warm with humour present … I feel he is at the point where he would accept anywhere that would provide him a bed*". Mr P was discussed at the forensic team meeting.

5.421 On 14 July Mr P was assessed by Ms C9 (this was their first meeting). Ms C9 gave Mr P some food vouchers. Mr P was not positive about various

members of staff from the forensic team and told Ms C9 that he was homeless, and that friends were getting fed up with him sofa surfing. Mr P asked Ms C9 to give him a lift to Ashley Cross to see a friend (it is now thought that this was Mr Merna).

5.422 Ms C9 has since (post homicide) stated that Mr P was:

> *"very good at making people feel sorry for him … she had been advised that [Mr P] was not at risk and following discussion was low risk and had been given the opportunity to go to the night shelter … was very 'whiney' at that time … constantly putting other staff down [Mr N1, Mr A3] … stating that nobody was helping him … [Mr A3] and [Mr N1] had advised her that [Mr P] was always like that … she knew he was staying with a friend at that time".*

5.423 On 19 July Mr P was again discussed in the forensic team meeting.

5.424 On 21 July a Care Programme Approach meeting was held that Mr P did not attend. Present were Dr S1 and Dr J2 but there are no entries in Mr P's contemporaneous records.

5.425 Ms B4 met with Mr P after the Care Programme Approach meeting.

5.426 On Friday 22 July Hope Housing confirmed to Ms C9 that Mr P's application had been declined because he was considered too high risk for their service. Mr P was assessed by Mr A3 who noted that Mr P had been saying he had nothing to live for. Mr A3 discussed Mr P's case with the crisis team and noted that Mr P appeared "*low in mood due to his housing situation*". It was agreed that Mr P could stay at a night shelter on condition that forensic team staff confirmed with the night shelter that Mr P could stay there with no money. When staff contacted the night shelter, they were told that the night shelter had no record of Mr P and had received no referral. It was noted that Mr A3 believed that Mr N1 had referred him originally. Mr A3 was unable to contact Mr P and therefore spoke to the crisis team staff again. It was noted that the referral to the night shelter would be made the following Monday. Mr A3 also contacted Ms B4 to ask for assistance in making a referral to the supporting people hub, because Ms C9 was due to be on leave the following week.

5.427 On Monday 25 July Ms B4 contacted the housing team to ask for a discussion about a referral to a night shelter or the YMCA. Ms B4 also emailed Mr N1 asking him to make contact to discuss funding bed and breakfast options, and tried (unsuccessfully) to call Mr P. Mr N1 noted that he saw Mr P late in the day "*sat outside Northover Court with [another client] … he looked OK?*"

5.428 First thing the following morning Mr N1 emailed Ms B4 to say he would call later and that he had seen Mr P the previous night. Ms B4 responded to say that Mr P had recently escalated threats to self-harm and asked if Mr N1 had made a housing referral. "*I am challenging the council on their view he has 'broken his local connection' by living away for a year but in the interim I believe we should offer B&B as we do [interim] for other vulnerable individuals*

… BBC [Bournemouth Borough Council] pay the B&B and BBC then claim back from housing benefit". Mr P was again discussed in the forensic team meeting when it was noted that he had "*Agreed to go into St Paul's Friday afternoon*". Mr N1 later responded to Ms B4 to advise that Mr P did not have a housing officer and that Mr N1 had referred Mr P "*direct to the two previous accommodations… He has made himself intentionally homeless and declined to accept advice (keep Northover open as an option) before he left Bournemouth*".

5.429 On 27 July Ms B4 emailed the supporting people hub and asked for a referral to the night shelter and feedback on any progress or information about Mr P's place on the waiting list. When Ms B4 later telephoned Mr P, he said he would re-consider St Michael's "*He confirmed that he does not have local connection, as I had previously believed. However he wants to settle in Bournemouth … his only local connection is being arrested in Bournemouth (this in fact constitutes BBC [Bournemouth Borough Council] [Section 117 aftercare] responsibility for him … said he is feeling cold, tired and missing medication because of the chaotic way he is living. He responded positively to suggestion of a tent and warm bedding*".

5.430 On 28 July Ms B4 spoke to Mr P who said he was going to approach a Poole bed and breakfast and "*thanked me for the support this week*". Ms B4 emailed her colleagues to advise that Mr P was willing to consider any option:

- she had arranged for a further St Michael's assessment (due to take place on 9 August);
- she had re-contacted Hope Housing;
- she e-mailed the supporting people hub to chase Mr N1's referral of 31 May;
- she had requested a referral to St Paul's through the supporting people hub;
- she had asked if anybody could donate a tent and sleeping bag.

5.431 Someone from the supporting people hub replied later making some suggestions and also expressing reluctance "*to refer someone with [Mr P's] mental health history to a generic single homeless hostel, when he required more specialist support*". It was also noted that "*[Mr P] is currently in a very favourable position on the waiting list for Leven House*". Ms B4 responded stating that Mr P had reported that he was sleeping in bushes outside Northover Court (having been barred from entering building), noting "*my colleagues have noted a slow decline in his ability to cope and in his physical well-being … is increasingly expressing the urge to self-harm and feeling hopeless*".

5.432 On Monday 1 August Mr A3 telephoned Mr P and noted that he "*Remains unhappy with the care that he is receiving … Reports that he has been playing around with his medication … declined a visit from myself today but*

happy to see [Ms C9] …". Ms C9 later advised that Mr P had told her that he had not received his benefits and was starving, however he had also said that a friend had been giving him breakfast. Ms C9 "*told him to go [to the Job Centre] to sort out his financial affairs*". She offered to take him to 'David Wells' later that day. He said he was waiting for a call from someone from the forensic team, and Ms C9 said she would call him later: Ms C9 noted "*It is my belief that [Mr P] was putting me off visiting and that this situation was not a matter of urgency. [Mr P] resisted support from me today*". Mr A3 noted that he had met with Ms B4 and Ms C9 and that "*much work has been done and there is a clear plan in place regarding his housing options*".

5.433 On 2 August Mr P called Mr A3 stating that he had no money or food, and his benefits had been stopped. He was signposted to the job centre and soup kitchens. When Mr P later attended the clozapine clinic covered in scratches, he told staff he was living in the bushes and disclosed that he was not always taking medication as prescribed.

5.434 On 3 August a member of staff called Ms C9 to advise that Mr P had requested his medical records for a [person appearing to be a doctor] to read through. Ms C9 then telephoned Mr P, who told her that he did not want [person appearing to be a doctor] to read his records, and that he no longer wanted his help with housing. Mr P said that he had not been to the benefits office, because he did not have an address, so he would not receive any money. Mr P also said that he did not want to go to David Wells to register. Mr P admitted that he had smoked a few joints and Ms C9 noted that Mr P "*presented as mumbling but not in the context of the conversation*".

5.435 On 4 August Mr P was assessed by Mr A3 who noted that Mr P was unshaven, had a bite mark and a swollen right eye. Mr A3 noted that Mr P "*was self centred with his needs and had to reminded of … the fact that he is homeless because he had refused the only options … It appears that his voices have been his inner dialect rather than his psychosis … benefits are now back in place …*"

5.436 On Friday 5 August Mr P was again assessed by Mr A3 who had been informed that Mr P was asleep in Northover Court grounds (staff at Northover Court had contacted the police about persistent trespassing). Mr A3 gave Mr P some him medication, and Mr P asked him to go away.

5.437 On Monday 8 August Mr P told Mr A3 (by telephone) that he was feeling physically ill, low in mood, and beaten by the system. Mr A3 informed Mr P of his housing appointment the following day, and Care Programme Approach meeting the day after that. Mr A3 noted that Mr P "*was still sleeping in the same location and reports that the police believe that the land doesn't belong to Northover so he is OK to remain until the owners raise their concerns*". Mr A3 noted that he had spoken to the social work team *"and we all agree that if tomorrow doesn't work out we will need to get [Mr P] off the streets as soon as we can*".

5.438 The following day Mr P was discussed in the forensic team meeting when it was noted "*Housing meeting today at St Michaels… Becoming a little unwell*".

Ms C9 collected Mr P from the grounds near Northover Court and Mr P asked if Miss Z8 could go with him. Ms C9 took Mr P to the interview at Michael House (hostel type accommodation rather than a night shelter), via a foodbank (at Mr P's request) in order to cash in food vouchers that he had been given over three weeks earlier. Ms C9 noted Mr P was "*looking well … open and honest …*". The manager at Michael House wanted more information after hearing about Mr P's history at Broadmoor (violence, weapons and threats to kill). Mr P was frustrated by this decision and said that he had had enough and was thinking about killing himself or committing a crime to get to prison. Ms C9 noted that she felt that Mr P was becoming increasingly low and needed to be accommodated as soon as possible. Ms C9 also noted that she thought that the decision was unreasonable, as Mr P was considered low risk citing "*he fled violence in Cornwall*". Ms C9 has since (post homicide) stated that it has subsequently materialized that Mr P was receiving £800 benefits and that she later felt he was 'playing' her. He looked clean, tidy and tired. He said he was no longer sleeping with friends but was living in the bushes. It appears that Miss Z8 was staying with Mr Merna (as a girlfriend), and that she was at Northover Court cooking for Mr P (in breach of rules). During the interview, he said he carried a knife to keep himself safe while homeless (this was not recorded in her clinical entry). Ms C9 later emailed Mr N1 requesting bed and breakfast accommodation funding stating "*his emotional well being is very poor at this time … may I ask that you consider this as a matter of urgency*".

5.439 On Wednesday 10 August Mr N1 asked Ms C9 for a full assessment of Mr P's needs, stating that risks to others had been low for many years. It was noted that the stumbling block may be that Mr P had made himself intentionally homeless in Bournemouth and Cornwall, and Mr N1 had also heard that he was planning to move in with his girlfriend from Northover Court. Ms C9 was informed that housing benefit would pay for bed and breakfast (possibly with his top-up); when she then called Mr P he told her he would look around.

5.440 Later that day an outpatient appointment and Care Programme Approach meeting were held with Mr A3 and Dr S1. It was noted that Mr P's physical health and diet were poor, that he remained unhappy and low in mood, and he was only partially compliant with his medication. Mr P's risks were considered to be increasing, and his housing situation was now urgent. Mr P's risks of suicide and harm to others were considered significant. Dr S1 noted Mr P "*remains well in his mental state … physical health is deteriorating … describes feeling hopeless and low in mood … alludes to thoughts of self-harm and offending if he does not get housing. I do think these risks are increasing … his housing need is now urgent as our ability to provide him with care and support is hampered by his situation*".

5.441 On Thursday 11 August Dr S1 wrote to Mr N1 noting "*I hope you are enjoying your new job … Initially we agreed that we should not reinforce impulsive behaviour and threats of suicide with accelerating the provision of housing … He has been sleeping rough … having I think burnt his bridges in terms of sofa surfing … His physical state is deteriorating as is his mood and he is not managing medication well … He has a severe mental disorder … we are*

unable to provide the healthcare he needs without him being housed … he needs urgently to be housed …". Mr P was assessed by Ms C9 (the final time that she saw him before Mr Merna's death). Ms C9 took Mr P to the benefits office, where she learned that he was already being paid £800 monthly in benefits. This is not mentioned in her entry into Mr P's clinical records. The planned bed and breakfast said they had no vacancies for two days, and that they charged what the benefits office considered to be "*too much*". Ms C9 dropped Mr P off at Northover Court. Ms C9 later telephoned Mr P to say she had found some accommodation from the next day, but he was negative and said he would take a cocktail of drugs to make him sleep. Ms C9 continued to make multiple efforts to find accommodation.

Friday 12 August 2016

5.442 At about 10:30am Ms C9 asked Mr P if he would pay £15 towards bed and breakfast accommodation, but Mr P said he could not do that. Ms C9 has stated that he was adamant that he could not afford this. Mr P said he would do things for himself, as he was fed up of being let down by the system and refused any offer of help. "*He said he wanted to find a flat so he could come and go and had his freedom*". (Ms C9 has since said that Mr P advised her not to bother any more with his accommodation and that he would organise it himself and that his speech was very slurred.)

5.443 At about 10:50am Ms C9 informed Mr N1 that Mr P's bank statement showed that he had funds of several hundred pounds.

5.444 At about 11:15am Ms C9 called Mr P to inform him he was high on list to go to Leven House and offered to support him registering with Housing. She noted Mr P "*was very non-committal about this*".

5.445 At 11:25am Ms C9 called David (Dave) Wells Properties about accommodation for Mr P. The housing provider asked for references but Ms C9 responded "*how can you expect homeless people to have references*". The housing provider suggested bed and breakfast accommodation and Ms C9 "*asked how can we expect to find a B&B this time of year*".

5.446 Ms C9 has retrospectively stated that "*when all options did not find [Mr P] accommodation I called [the Trust bed manager] to discuss other options. She suggested that he has a bed on Twynham for the weekend. When suggested to [Dr S1], he stated that it would not be a suitable option for [Mr P]*".

5.447 Later this day, Mr P was seen (we think by Ms B4) with a six pack of beer/lager cans with friends outside Northover Court, appearing jovial and happy.

5.448 Mr A3 has since advised that Mr P:

"*had never been sleeping rough as residents at Northover Court allowed him full use of their facilities … [he] was using [Hans Blood character] for the purpose of gaining services, specifically accommodation, from the Trust [he]*

was often unhappy with services, feeling that not enough effort was being made for him … he wanted to hand [Mr P] over to the crisis team for the weekend … [they] declined intervention … [Mr A3] escalated the matter to the most senior person available … [his] low mood was attributable to his housing problems … wasn't aware of the previous diagnosis of psychosis".

Sunday 14 August 2016 – death of Mr Merna

5.449 At about 1:35pm Mr P killed Mr Merna in his flat where he lived alone. Mr P stabbed Mr Merna multiple times in the head, groin and chest.

5.450 On examination after his arrest, it was noted that Mr P had a stab wound to his thigh, appeared agitated and was sweating profusely. Mr P admitted taking alcohol that morning. Mr P referred to Mr Merna as a rapist, said he hoped he would die, and (then) was glad that he had died.

5.451 A Mental Health Act assessment was completed that evening during which Mr P said he needed to die. The assessing doctor (who was not on the specialist register) noted evidence of "*possible malingering … suggestive of malingering behaviour*". Mr P said that "*Hans Blood*", not he, had done it. Mr P did not answer many questions, which was described as appearing to be "*an intentional approach*". Mr P was not detained as he was considered not to be psychotic and "*able to take full criminal responsibility for his actions*". The "*recorded diagnosis on the system*" was mixed personality disorder with antisocial and emotionally unstable characteristics.

5.452 Mr P later reported had been staying at Mr Merna's address for a few weeks (unknown to Trust staff) but not the previous night. Mr P also said that both he and Mr Merna had been using drugs but that after he had told Mr Merna he would no longer obtain drugs for him, Mr Merna asked Mr P to leave his (Mr Merna's) flat. After this Mr P had slept in bushes, drinking and using cannabis.

Monday 15 August 2016

5.453 Mr P's solicitor requested a second Mental Health Act assessment and Mr P was transferred to HMP Winchester.

Thursday 18 August 2016

5.454 Mr P was referred to Broadmoor because he was "*making statements which are suggestive of psychosis … reported he had not been taking his clozapine for a week since he had not been eating properly*".

Friday 19 August 2016

5.455 Ms C9 made a retrospective entry, indicating that when Mr P had been assessed by Michael House Mr P had said he kept a knife to keep himself safe when homeless. Ms C9 also added that she spoke to the bed manager the previous Friday, the bed manager had had suggested a bed on Twynham Ward for the weekend, but that this had been declined by Dr S1.

6 Duty of Candour

6.1 Duty of Candour applies when an NHS organisation becomes aware that a notifiable patient safety incident has occurred. A notifiable patient safety incident includes the death of a service user.

6.2 We have reviewed the Trust's recording of its actions under the Health and Social Care Act Regulation 20: Duty of Candour, introduced in April 2015. The Regulation is also a contractual requirement in the NHS Standard Contract.

6.3 In interpreting the regulation on the duty of candour, the Care Quality Commission uses the definitions of openness, transparency and candour used by Sir Robert Francis in his inquiry into the Mid Staffordshire NHS Foundation Trust. These definitions are:

- *"**Openness** – enabling concerns and complaints to be raised freely without fear and questions asked to be answered.*
- ***Transparency** – allowing information about the truth about performance and outcomes to be shared with staff, patients, the public and regulators.*
- ***Candour** – any patient harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it."*

6.4 To meet the requirements of Regulation 20, a registered provider has to:

- *"Make sure it acts in an open and transparent way with relevant persons in relation to care and treatment provided to people who use services in carrying on a regulated activity.*
- *Tell the relevant person, in person, as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, and provide support to them in relation to the incident, including when giving the notification.*
- *Provide an account of the incident which, to the best of the provider's knowledge, is true of all the facts the body knows about the incident as at the date of the notification.*
- *Advise the relevant person what further enquiries the provider believes are appropriate.*
- *Offer an apology.*
- *Follow up the apology by giving the same information in writing, and providing an update on the enquiries.*
- *Keep a written record of all communication with the relevant person."*

6.5 We have included the full excerpt of the regulations at Appendix D.

6.6 Duty of Candour is referenced within the Trust Policy for Reporting and Management of Incidents including Serious Incidents. In section 8 of this policy the Trust states that the Duty of Candour applies "*as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred*" a health service body must notify the "*relevant person*". The policy describes that the relevant locality manager (or nominated deputy) will contact the patient and family and will provide an account of what has happened, advise what further enquiries into the incident the Trust believes to be appropriate, including an apology.

6.7 The policy goes on to states that:

> *"For those incidents that require further investigation such as pressure ulcers and unexpected deaths/suicides a Root Cause Analysis review is carried out. It is current practice of the Trust for families and carers to be invited to be part of the incident review. If it becomes apparent that the incident was as a result of failings in care then the Duty of Candour process is commenced by the Locality Manager (or nominated deputy) as identified via the review."*

6.8 The Trust also has a specific Being Open (Duty of Candour) policy. This policy makes it clear that saying "sorry" is not an admission of liability and is the right thing to do. It also states that patients and/or carers should receive an apology as soon as possible after a patient safety incident has occurred.

6.9 This policy is clear that:

> *"…the patient and/or their carer should receive a sincere expression of sorrow or regret for the harm that has resulted from a patient safety incident. This should be in the form of an appropriately worded and agreed manner of apology, as early as possible."*

6.10 The regulations are clear that the "*relevant person*" to whom Duty of Candour applies means the service user, or on the death of the service user, a person acting lawfully on their behalf.

Communication with Mr P

6.11 We have not seen any evidence that the Trust sent any communication to Mr P. However, it would be very challenging to apply Duty of Candour law in relation to Mr P. This is because at the point that Mr Merna's death became a notifiable event it was not clear that the Trust had failed in its duty of care towards Mr P.

6.12 However, the Trust should consider in retrospect whether Duty of Candour should have been applied at the point when either:

- they commissioned an investigation into Mr P's care and treatment; or

- the investigation report was finalised and there were recommendations made about the care and treatment provided to Mr P.

Communication with Mr P's family

6.13 Mr P's son does not strictly fulfil the criteria of the definition of a "*relevant person*" within the regulations. However, the Trust did write to him and provided us with a copy of that letter as evidence that they had fulfilled their Duty of Candour responsibility towards him. We consider that communicating with Mr P's son was appropriate and within the spirit of the regulations.

6.14 The Trust wrote to Mr P's son in Cornwall on 31 August to inform him that an external investigation had been commissioned in response to the significant event involving his father. The nature of the letter indicates that Mr P's son was already aware of the incident, but we are not aware of any other correspondence or communication between the Trust and Mr P's son after Mr Merna's death. The letter invited Mr P's son to provide his views on the care and treatment provided to Mr P. The Trust did not receive a response to this letter and did not contact Mr P's son again.

6.15 The letter did not offer an apology, as is required within Regulation 20 and the Trust's own policy. Also, the letter did not directly offer support (as is also required within Regulation 20) but indicated that the Trust hoped that support was available to Mr P's son.

6.16 Given that the correspondence with Mr P's son was not required by Regulation 20 (because he was not a "relevant person") we cannot say that the Trust failed in the execution of its Duty of Candour responsibilities towards him. However, we would suggest that the Trust considers the content of correspondence that it does send when communicating within the spirit of Regulation 20.

6.17 See our Recommendation 10.

Communication with Mr Merna's family

6.18 The death of Mr Merna on 14 August was a notifiable incident because it was suspected that he was killed by someone (Mr P) who was in receipt of mental health care and treatment provided by a specialist mental health service provider.

6.19 The Trust formally reported Mr Merna's death on 16 August 2016 and completed an initial 72-hour report on 17 August. At this point Duty of Candour applied to Mr Merna's family because they were acting on his behalf after his death.

6.20 An investigation was later commissioned into both Mr Merna's care and treatment and Mr Merna's family was informed of this on 31 August in a letter from the Medical Director. This was the first formal contact that Mr Merna's family received from the Trust. The letter did not offer an apology, as is required by Regulation 20, although the Trust did offer their condolences. It is

clear from our discussions with the Trust that the Trust believes that they did execute their Duty of Candour responsibilities by offering condolences and support to Mr Merna's family. However, we do not consider that providing condolences is the same as offering an apology in accordance with Regulation 20. Indeed, Mr Merna still considers that the Trust has never apologised for the death of his son.

6.21 NHS Resolution guidance is clear that using the word "sorry" is an integral part of the Duty of Candour process. Whilst the letter of 31 August was provided as evidence of Duty of Candour, the Trust has subsequently provided us with copies of two other letters:

- 24 August 2016 – personal letter from Dr E1 saying sorry to hear of Ryan's death;
- 8 March 2017 – letter from Trust Chief Executive expressing personal condolences

6.22 Mr Merna has told us that he does not accept Dr E1's letter as an apology on behalf of the Trust and has reiterated that he believes he is still to receive an apology from the Trust for the death of his son.

6.23 The letter of 31 August also advised that because of the nature of the event the Trust had commissioned an external investigation that would be undertaken by a consultant forensic psychiatrist, Dr Y. The intention would be for Dr Y to:

> *"objectively review the health care and treatment provided by our Trust to your son Ryan. The purpose of this is to identify any learning as to how health care and treatment was delivered and whether the Trust needs to put any actions in place to prevent similar events from occurring"*

6.24 The terms of reference were agreed by the Trust and shared with Mr Merna's family with an invitation to contribute to the investigation. A date for receipt of the report was set for 14 October 2016.

6.25 Mr Merna's family responded on 5 September to ask for more information about the terms of reference for the investigation, and to seek clarity about whether it would also review the care and treatment provided to Mr P.

6.26 The Medical Director responded the following day to advise that the investigation would review the care and treatment provided to Mr Merna and Mr P.

6.27 The Trust had no communication with Mr Merna's family about his funeral but on 7 September Mrs Merna contacted Dr B2 (with whom she also had a personal relationship due to the fact that their young children were in the same class at school) to say that Mr Merna's family was happy for staff and other patients to attend his funeral on 16 September.

6.28 Mr Merna (senior) emailed the Medical Director on 22 September apologising for the delay in responding but advising that he wanted to fully consider the information the Medical Director had provided. Mr Merna asked for more background information on the investigating officer, Dr Y. Mr Merna was keen to establish Dr Y's "*true independence*" and her qualifications and relevant professional experience. Mr Merna stated that he was uncomfortable with the objective:

> *"To establish whether failings or omissions occurred in care or treatment and to look for improvements rather than to apportion blame"*

6.29 Mr Merna indicated that he felt this narrowed the remit of the investigation and wanted to know what action would be taken if an individual, or individuals, were found to be culpable in some way.

6.30 The Medical Director responded the following day providing a summary of Dr Y's experience in reviewing cases and qualifications. The Medical Director also outlined the purpose of the review and highlighted that all such cases were subject to external review and scrutiny.

6.31 Mr Merna responded to the Medical Director on 4 October to advise that both he and Mrs Merna would like to be involved in the investigation and invited the Medical Director to make contact to agree a date and venue for a meeting. Mr Merna also asked to meet Dr Y before the report was completed. A telephone conversation was subsequently arranged.

6.32 The telephone conversation between Mr Merna and Dr Y took place prior to 20 October (the actual date is unclear from information provided by the Trust). Dr Y reported that Mr Merna was understandably very upset and had asked her to share a copy of her report regarding Mr P. Dr Y had told Mr Merna that she did not have Mr P's consent to disclose any information to Mr Merna, and therefore was unable to share her report. Dr Y advised that she had offered to call Mr Merna the following week, but reported to the Trust that they would have to decide how to manage Mr Merna's request to see information about Mr P.

6.33 It is our understanding that the Trust sought legal advice about sharing the full report into Mr P's care and treatment with Mr Merna. We have not seen a copy of this advice. The Trust has advised that it acknowledges the frustration that this advice has caused to Mr Merna, however the organisation referred to the fact that it has no justification to release confidential third party information that is not already in the public domain to Mr Merna.

6.34 The Trust has not revisited the legal advice since Mr P's trial. In discussions with us the Trust has acknowledged that it would be appropriate to return to pre-trial decisions after a trial has concluded.

6.35 Mr Merna's family has received a copy of the investigation report into their son's care and treatment, but they have not received a copy of the investigation report into Mr P's care and treatment. However, the Trust has

shared a copy of the action plan that includes the recommendations from the internal investigation report.

7 Internal investigation and action plan

7.1 The Trust was aware that Mr P was the suspect in the death of Mr Merna on 14 August 2016. The Trust reported the incident to the NHS Dorset Clinical Commissioning Group on 16 August and completed an initial 72-hour report on 17 August.

7.2 By 31 August the Trust had taken the decision, "*due to the nature of this event*" to commission an external investigation to be undertaken by a consultant forensic psychiatrist (Dr Y). The Trust has told us that for inpatient deaths and for homicides they consider commissioning someone completely independent to do to the review, which was the decision taken for this investigation.

7.3 The terms of reference for the internal investigation have been provided to us by the Trust and we have provided these at Appendix E.

7.4 Because Mr Merna (senior) had questioned the Trust about Dr Y's independence we asked her about this at interview. Dr Y told us that the Trust did not ask her about any conflicts of interest when they approached her to undertake the investigation.

7.5 Dr Y told us that she was a former colleague of both Dr E1 and Dr S1 and that it was difficult to work in the world of forensic psychiatry without finding consultants that did not know each other. However, these professional relationships did not impact on her independence and that she would always state her views regardless of the presence or otherwise of a professional relationship. Dr Y said that she did consider potential conflict of interest but considered that from her perspective there were none. However, the Trust had never asked her to formally declare any relationships prior to commissioning her to undertake the investigation.

7.6 Dr Y interviewed 13 members of staff, of whom six were involved in Mr Merna's care and treatment only. Notes were retained from these interviews and we have had access to these.

7.7 On 20 October 2016 the Trust received an initial draft report from Dr Y, relating only to Mr P. At this time Dr Y advised pausing the investigation until January or February 2017 to allow the court case to conclude and for legal advice to be sought about what could be shared with Mr Merna's family regarding Mr P's care and treatment.

7.8 It is not uncommon for an internal investigation to be suspended when there is an ongoing police investigation.

Care or service delivery problems

7.9 The investigation report is not set out in the format prescribed by NHS England in the Serious Incident Framework. However, the report does provide narrative on:

- diagnosis, including:
- post-traumatic stress disorder;
- schizophrenia;
- substance misuse;
- personality disorder;
- medical management;
- accommodation.

7.10 Dr Y's conclusions were that the evidence suggested the following diagnostic formulations:

- *Personality disorder with dissocial and emotionally unstable characteristics: the latter evidenced by [Mr P's] tendency to emotional dysregulation, self-harm, and difficulties in trust and relationship, and the former by his adult offending history and the presence of conduct disorder in childhood and adolescence.*
- *Poly-substance misuse – by his own account and the records he was a prolific user of alcohol and amphetamines, and other drugs such as butane gas and cannabis…the relative importance of his alcohol misuse history was under-estimated, as the early reports suggest that much of his early offending was alcohol related, and he himself and reported 'uncontrollable rage' when intoxicated with alcohol.*
- *PTSD/Complex Trauma – [Mr P] had had sufficient adverse experiences to produce such a disorder, and had reported that his substance misuse, initially at least, was a form of self-medication for the symptoms of trauma. His symptoms included flashbacks and nightmares (and associated incontinence) and his deep-seated and persistent antipathy to those he perceived to be child sex offenders was linked to this.*
- *Schizophrenia – [in Dr Y's opinion] there is plentiful evidence of psychotic symptoms consistent with this diagnosis. The types of auditory hallucinations reported by [Mr P] consistently over many years are not typical of the voices heard by people with [emotionally unstable personality disorder], and he also had classical schizophrenic symptoms such as delusions of the control of thought. It may be that this disorder was precipitated by amphetamine use initially, but the nature of his psychosis remained relatively stable through his time in secure services: command hallucinations associated with abnormalities in the control of thought, and graphic thoughts of harm to others.*

7.11 Dr Y summarised that "*overall the delivery of care to [Mr P] was good"* and that there were aspects of his care that were commendable, "*most particularly*

the rapid response when the Cornwall services discharged him from their caseload".

7.12 Dr Y also commended the team for their "*fairly open and reflective attitude for the most part*" with her.

Recommendations

7.13 Dr Y did not make SMART recommendations but listed ten areas for improvement and three suggestions for reflection. We do however agree that these areas for improvement were relevant and were evidenced by Dr Y's findings.

Areas for improvement

1. *"The impediments to the **reappraisal** of new admissions in terms of diagnosis, risk, and treatment needs, need to be considered by the [Dorset Forensic Team]. The lack of a detailed summary review of previous notes, and the acceptance of the 'perceived truth' from Ravenswood was a failing that compounded that earlier diagnostic error and may have had the most significant effect on the care [Mr P] received.*

2. *An identified forum where diagnostic issues are specifically discussed by the team, and where reviews of past records and/or current mental state can be presented and discussed. This may not need to be a very lengthy process for some patients, but for those stepping down from high and medium security, it probably does need to have some time devoted to it. Perhaps a formulation meeting within a month of admission would be a way to do this.*

3. *An identified and realistic process for managing homeless patients within the service – some type of flow chart and 'key people' document could be constructed to facilitate interventions on the rare occasions this situation arises unexpectedly. It seems that a lot of effort was spent trying to find out how to do some of the things, rather than actually doing them – some of the criteria for placement were not known until the placement had turned down [Mr P]. Some advance awareness of these might assist in future. The risks associated with homelessness are well know[n].*

4. *The system of managing the re-presentation of previous patients should be reviewed. There is a need to balance the urgency of intervention with a measured review of the relevant issues. The rapid reintegration of [Mr P] to the team was commendable, but the lack of a structured MDT reassessment in a timely manner thereafter was not. The team, and other services, made assumptions about the meaning of some of [Mr P's] presenting features, (which leads on to a further issue about how patients with personality disorder are perceived – see below) and became focussed [sic] on the accommodation issue to the exclusion of wider issues of risk and diagnosis.*

5. *There should be a standard assessment of [post-traumatic stress disorder] symptoms within the admissions process – trauma symptoms are commonly found in the forensic population, but unless asked directly and in a structured way, patients may not volunteer such information. There are recognised and effective treatments so it is important that this diagnosis is considered in every patient.*

6. *There should be KPI's for consultants to see and assess patients face to face outside wardrounds, on a monthly basis, or similar standard frequency.*

7. *There should be a KPI for the team psychologist to have assessed, and prepared a provisional formulation on patients within one month of admission.*

8. *Each patient should have an individualised crisis plan that includes actions to be taken in the event of a presentation to out of hours services or sudden changes in circumstances.*

9. *There should be a review of testing for alcohol and drugs such that more sophisticated substances, such as Spice (sic) or other synthetic agents can be tested for, and also consideration of using blood tests for alcohol use.*

10. *There should be a mechanism for inpatients to access expert primary care – for example an arrangement with a local GP practice."*

Suggestions for reflection

1. *"[Dorset Forensic Team] to reflect on the management of the risk factors presenting in 2016 and why the response in 2016 was different from the response to a lesser degree of disturbance in 2013.*

2. *[Dorset Forensic Team] (and the [criminal justice liaison department] and [psychiatric liaison] services) to reflect on their own attitudes towards patients with personality disorder management of [personality disorder], and on how biases/assumptions can lead to [personality disorder] becoming a diagnosis that impairs rather than allows access to mental health services. People, including people with personality disorder, do things for good reasons, and in [Mr P's] case, it could be argued that his understanding of his risks was better than the team's – trying (not necessarily very skillfully [sic]) to secure admission to hospital, or a safe environment, was actually a functional behaviour in terms of him managing his own risks.*

3. *The [Dorset Forensic Team] to reflect on their use of, and access to, informal or out of area admission arrangements for forensic patients in crisis"*

Analysis of Trust internal investigation report

7.14 The Trust asked an experienced and highly regarded consultant forensic psychiatrist to complete what was essentially an expert clinical report. Dr Y identified a number of areas for improvement.

7.15 The NHS England Serious Incident Framework provides detailed guidance about the nature of the final serious incident investigation report. It states that the reports must be shared with key interested bodies including patients, victims and their families. NHS England recommends that reports are drafted on the basis that they may become public documents and therefore issues of anonymity and consent for disclosure of personal information are important.

7.16 NHS England also states that the report should:

- Be simple and easy to read;
- Have an executive summary, index and contents page and clear headings;
- Include the title of the document and state whether it is a draft or the final version;
- Include the version date, reference initials, document name, computer file path and page number in the footer;
- Disclose only relevant confidential personal information for which consent has been obtained, or if patient confidentiality should be overridden in the public interest. This should however be considered by the Caldicott Guardian and where required confirmed by legal advice;
- Include evidence and details of the methodology used for an investigation (for example timelines/cause and effect charts, brainstorming/brain writing, nominal group technique, use of a contributory factor Framework and fishbone diagrams, five whys and barrier analysis);
- Identify root causes and recommendations;
- Ensure that conclusions are evidenced and reasoned, and that recommendations are implementable;
- Include a description of how patients/victims and families have been engaged in the process;
- Include a description of the support provided to patients/victims/families and staff following the incident.

7.17 The Trust internal report does not meet many of the standards set out by NHS England.

7.18 We asked Dr Y what knowledge she had of the NHS England Serious Incident Framework. At the time of interview Dr Y stated that she had no knowledge of the Serious Incident Framework and later clarified that at the time of writing the report she was not familiar with the NHS England document. Dr Y told us that she now has a basic knowledge of the NHS England Serious Incident Framework but that she was not an expert in the details of its application in NHS Trusts, and that on reflection she should have paid more attention to that when first approached by the Trust to undertake the investigation.

7.19 Dr Y told us that she believed the Trust had approached her because she is quite well known in the field of forensic psychiatry.

7.20 Dr Y told us that she understood that she did not use root cause analysis "*forms*" for this investigation. She had done so for the previous investigation that the Trust had asked her to undertake but had found they were "*quite unwieldy and not particularly helpful*" so she followed what she considered to be "*the logical pathway, which was to identify any areas in the care and treatment of both parties which were good, acceptable, not so good and needed improvement*". Dr Y submitted a draft report to the Trust before the final version and was not told that the Trust wanted the report presented differently. Dr Y's view was that she could not have written the report in any other way to be able to focus on the diagnostic issues.

7.21 The Trust provided Terms of Reference for the investigation that included the production of a final report that could be published. This Term was not met.

7.22 Dr Y explained that her understanding was her findings would be shared verbally with Mr Merna's family and she didn't recall expecting the full written report to be shared. Dr Y believes that she assumed that if a written document were to be shared, this would be "*some form of executive summary of the main issues*".

7.23 The Trust told us that they believed that Dr Y was clear that she was being asked to undertake a single Level 2 investigation reviewing the care and treatment provided to both Mr P and Mr Merna. Although the Trust commissioned a single Level 2 investigation, Dr Y provided two narrative reports and two separate detailed chronologies, so four documents in total.

7.24 Dr Y was not an independent investigator, she is a consultant forensic psychiatrist who was asked by the Trust to conduct the review. Dr Y worked on her own (rather than with a multi-disciplinary investigation team), had no knowledge of the Serious Incident Framework and has only undertaken two independent investigations, both for the Trust.

7.25 The Trust as the report commissioner, was responsible for ensuring that the investigation was conducted by someone with the appropriate skills, knowledge and understanding of both:

- the issue being investigated, and
- conducting an investigation.

7.26 The terms of reference set by the Trust for the internal investigation state that it was a level 2 investigation. The Trust and the clinical commissioning group have at times indicated that they believe it was an independent investigation, therefore level 3.

7.27 Appendix 3 of the SIF states that there are two types of independent investigation:

- Provider focussed – to be commissioned by the commissioner of the care within which the serious incident occurred;
- Focussed on the commissioning system or configuration of services – to be commissioned and undertaken independently of the aspects of the system under investigation.

7.28 The internal report does not meet the criteria for either type of independent investigation.

7.29 The Trust told us that Mr Merna's report (both the narrative report and the detailed chronology with information redacted that related to Mr P or other third parties) was shared with his family. The Trust had left in initials of those in Mr Merna's care team because his family were aware of the names of individuals who worked with him.

7.30 The Trust has told us that they received legal advice that stated they could not share the internal report (of Mr P's care and treatment) with Mr Merna's family. We believe that had the internal report been written in accordance with the standards set out in the NHS England Serious Incident Framework, this issue would not have occurred.

7.31 Dr Y told us that in her opinion was that the "*root cause was that the diagnosis [of personality disorder] was wrong*" and that this was how she wrote her report. Dr Y also told us that the diagnosis of paranoid schizophrenia had been "*lost in translation*" between Broadmoor and Ravenswood House. Dr Y told us that she considered a complicating factor to be the change in the Mental Health Act because, in 2007, following the revision, there ceased to be legal classifications. In 2006 if somebody was detained on the grounds of mental illness and personality disorder, by 2008 there was no classification because the law had changed. Therefore, a reminder that someone was detained for more than one reason, had been lost.

7.32 There was also a requirement to identify care and service delivery problems that may be contributory factors or root causes to the incident. Although they were present in Dr Y's report, they were not presented in a way that would have been clear to a lay person.

7.33 We do not dispute any of Dr Y's findings, but they had a significant focus on diagnosis and medical behaviours (all of which were relevant). The Trust and the clinical commissioning group have at times asserted that Dr Y's report was a level 3 investigation. A level 3 investigation focusses on systems, as well as the component parts of those systems.

7.34 It is our view that not all key issues and lessons were identified in Dr Y's report. We have addressed further areas of learning in Section 8.

7.35 A recent inspection of the Trust by the Care Quality Commission (April 2018) stated:

> *"There was a lack of consistency in the documentation of investigations into serious incidents that had occurred. While some investigations had identified clear root causes to incidents and then appropriate learning drawn from detailed recommendations, other investigations had not. A number of investigations into incidents involving mental health patients did not demonstrate sufficient scrutiny or depth of investigation, and others appeared to draw narrow learning."*

7.36 We acknowledge that this is a general statement, but we consider it to be relevant because it is evidence from another organisation that has identified similar concerns about serious incident investigations.

7.37 See our Recommendation 1.

Analysis of Trust action plan

7.38 The latest version of the action plan that we have analysed was presented to the Quality Governance Committee on 14 March 2018. The action plan lists the ten areas for improvement set out in Dr Y's report and as at March 2018 progress in three areas (1, 6 and 10) for improvement was shown as amber:

1. *"The impediments to the **reappraisal** of new admissions in terms of diagnosis, risk, and treatment needs, need to be considered by the [Dorset Forensic Team]. The lack of a detailed summary review of previous notes, and the acceptance of the 'perceived truth' from Ravenswood was a failing that compounded that earlier diagnostic error and may have had the most significant effect on the care [Mr P] received."*

7.39 The Trust reported that funding for a new consultant forensic psychiatrist had been agreed. The post had gone through appropriate recruitment processes and had been offered to an individual in October 2017, in March 2018 it was reported that the start date had not been agreed. We learned in June 2018 that the consultant had recently started in post. The Trust also reported a request had been made to NHS England commissioners for an increase in the funding for the low secure ward (Twynham Ward) and that if this was approved, the Trust would increase the psychology resource within forensic services. We were advised in January 2019 that the additional psychology resource will be in place in March 2019. We have not seen evidence of how the Trust is linking this additional resource to the increase in reappraisal of new admissions. We consider that the Trust should take further action to assure themselves and their commissioners that this additional resource delivers the required results.

6. "There should be KPI's for consultants to see and assess patients face to face outside wardrounds, on a monthly basis, or similar standard frequency."

7.40 The Trust was reviewing what key performance indicators for consultant psychiatrist contact time were currently achievable and were considering assessing themselves against national benchmarking data to develop a best practice plan. The Trust was waiting for the arrival of the new consultant and planned to use the Assistant Psychologist in the forensic service to audit the standards when they were implemented. It is our view that this action remains incomplete because there are still no key performance indicators.

10. "There should be a mechanism for inpatients to access expert primary care – for example an arrangement with a local GP practice."

7.41 The Trust had agreed with the Clinical Commissioning Group that a GP with a special interest (in mental health) would be recruited to attend St Ann's Hospital to assess, monitor and advise on the physical health needs of patients during their admission. We were advised in January 2019 that the post had been filled.

7.42 All other actions were indicated as complete and audits were in place to evidence this. We consider that where the identified learning has been implemented, there was evidence to support positive changes in clinical practice and embed those changes in business as usual.

7.43 The Trust has provided us with copies of the relevant minutes relating to meetings of the Quality Governance Committee and Executive Quality and Clinical Risk Group when the investigation and/or action plan for this incident was reviewed and discussed.

7.44 We can see that the investigation into the care and treatment of Mr P has been discussed by the Quality Governance Committee on seven occasions between October 2016 and April 2018 (the date that the documents were provided to us):

- 20 October 2016 – noting that there had been 12 incidents in Quarter 2 (1 July to 30 September 2016) that met the Duty of Candour requirements and they were all related to avoidable pressure ulcers.
- 19 January 2017 – noting that an independent external review had been requested;
- 20 July 2017 – noting that the investigation into the homicide of a community patient had been carried out independently [by Dr Y];
- 20 September 2017 - noting that Niche had been commissioned to undertake the independent investigation;
- 15 November 2017 – noting that Mr P had been found guilty of manslaughter on the grounds of diminished responsibility and that

sentencing had not taken place, a copy of the Trust action plan had been shared with Mr Merna's family;

- 10 January 2018 – noting that a pre-inquest hearing had been held on 5 December 2017 in relation to Mr Merna's death, a further hearing had been requested by the Coroner in June 2018, after the expected completion of the independent [Niche] report;

- 14 March 2018 – a full review of the Trust action plan.

Clinical Commissioning Group monitoring of action plan

7.45 NHS Dorset Clinical Commissioning Group was responsible for approving the internal investigation report and action plan, and monitoring progress of Trust actions.

7.46 The NHS England Serious Incident Framework states that the commissioner (in this case NHS Dorset Clinical Commissioning Group) must seek assurance that the report fulfils the required standard for a robust investigation and action plan.

7.47 In addition, the NHS England Serious Incident Framework states that commissioners should work with their providers to encourage and support publication of reports and action plans, and that reports should not contain confidential personal information.

7.48 As we have stated previously the Trust internal investigation report does not meet the standards set out by NHS England, but this was not challenged by the Trust commissioners.

7.49 The Clinical Commissioning Group has informed us that they did not consider that the Trust's internal investigation report required challenge. The Clinical Commissioning Group has supported their position by citing the lack of concerns raised about the quality of the report by the Adult Safeguarding Board. However, the Chair of the Adult Safeguarding Board had stated that at no point was the internal report made available to the Safeguarding Adult Board. We understand that the report was shared in confidence with the Chair only to help him determine whether to commission a Safeguarding Adults Review. We understand that this fact was made clear at meetings of the Safeguarding Adults Review sub group. In addition, the Chair has stated that they do not remember being asked by the clinical commissioning group to comment on the quality or methodology of the report.

7.50 The Clinical Commissioning Group has asserted that the NHS England Serious Incident Framework is open to interpretation and does not accept our analysis that internal investigation report does not meet the standards set out.

7.51 The Clinical Commissioning Group has advised that they have been monitoring the actions taken by the Trust in response to the internal investigation report. The initial draft findings and action plan were shared with the clinical commissioning group in November 2016 and were reviewed at the

regular quality catch up meetings that form part of the contract monitoring process with the Trust.

7.52 The Trust shared the internal investigation report with the clinical commissioning group on 23 January 2017. We understand that the report was not formally reviewed through the clinical commissioning group's incident review panel process because the case remained under investigation due to the criminal proceedings and the forthcoming NHS England independent investigation (i.e. this investigation).

7.53 The evidence of tracking that the Clinical Commissioning Group has provided to us only starts on 25 May 2017. The summaries included refer to transactional information and focus on the process of the criminal trial and our independent investigation. We understand that the action tracker serves as a prompt for discussions and it is not a complete record of discussions that take place. In addition, the minutes and notes of formal contract meetings will not specifically mention any individual case but there are specific actions in key areas that are monitored such as development of individual crisis plans, risk assessments of new admissions to the service, and improving access to physical health and primary care (for example).

7.54 The Clinical Commissioning Group has told us that there were "*considerable ongoing discussions*" regarding the progress with the investigation and the subsequent next steps prior to May 2017 but they are not able to access any evidence because the previous Director of Nursing has since retired.

7.55 The Trust provided the Clinical Commissioning Group with some emails containing evidence of some of the discussions between the Clinical Commissioning Group and the Trust and has provided us with a summary of the content of those emails. We have set these out in Table 3 below.

Table 3 – Summary of email communication between the Clinical Commissioning Group and other agencies regarding the Trust internal investigation and action plan

Date	Summary of email
27 October 2016	Email from Chair of the Adult Safeguarding Board confirming Clinical Commissioning Group Director of Nursing had contacted NHS England regarding the need for an independent inquiry.

Date	Summary of email
11 November 2016	Email from NHS England to Clinical Commissioning Group Director of Nursing requesting that a copy of the internal investigation report that had been discussed by NHS England and Chair of the Adult Safeguarding Board be received by 22 November, in order that NHS England could decide about whether to commission and independent investigation. Clinical Commissioning Group Director of Nursing liaised with the Trust who confirmed that the draft internal investigation report had been discussed at the serious incident panel on 21 October 2016 and that the reviewer had requested an extension to delay completion until after the trial in January 2017. No immediate actions were identified at that panel.
28 November 2016	The Trust shared the draft internal report with NHS England.
14 February 2017	The Trust confirmed that the final report was shared with NHS England, the Adult Safeguarding Board and the Clinical Commissioning Group. The Trust also advised that the action plan was being developed by the team involved.
18 July 2017	Papers were received by the Clinical Commissioning Group Director of Nursing regarding the initiation of the independent investigation.

7.56 The Clinical Commissioning Group has advised that they do not consider the action plan to be complete because the findings of this independent investigation will "*inform and potentially add to this plan*".

7.57 The NHS England Serious Incident Framework states that it is the responsibility of the commissioning organisation to ensure that "*…the report, action plan and implementation of necessary actions meet the required standard…*". The Serious Incident Framework provides a checklist tool that can be used by both providers and commissioners to evidence their assessment of the quality of the investigation report and action plan. Whilst it is not a requirement to use this tool, it is best practice and it provides an audit trail for the assessment of serious incident reports.

7.58 We have received information about the process that the Clinical Commissioning Group has followed, but no detail about how they have assured themselves about the implementation of the action plan.

7.59 It is our opinion that the Clinical Commissioning Group should have challenged the quality of the Trust internal investigation report and required the Trust to produce a report that complied with the standards set out in the NHS England Serious Incident Framework. See our Recommendation 2 and Recommendation 3.

8 Discussion and analysis of Mr P's care and treatment

8.1 Our findings are broadly consistent with that of the internal investigation team, however we have discussed a number of themes in more detail below. Care and service delivery problems can be found in Appendix F.

Diagnoses and treatment

8.2 Between 1996 and 2016, the primary diagnosis given to Mr P was one of "*personality disorder*", complicated by substance misuse. This was most commonly specified as a "*mixed personality disorder*", and at different times borderline, paranoid, dependent, antisocial / dissocial, emotionally unstable, and dependent traits or features were also specified. However, the records we have been able to see also clearly indicate that from no later than April 2006 (and continuing until his transfer in March 2009) clinicians at Broadmoor regarded Mr P as suffering from a psychotic disorder (specifically, paranoid schizophrenia). This diagnosis was not made at all after January/February 2012, although, as we have noted above, Dr Y has clearly questioned the accuracy of that position.

8.3 Throughout Mr P's care and treatment in mental health services, spanning 20 years, he had two significant diagnoses, personality disorder and schizophrenia. Table 4 below provides a summary of when those diagnoses were made, and the associated treatment provided.

Table 4 - Significant diagnoses/legal category and associated treatments

Date	Diagnosis/legal category for detention	Medication
May 1996	Initial: differential diagnosis amphetamine psychosis or psychotic depression On discharge: mixed personality disorder and substance misuse	"*Significant amounts of antipsychotic medication including haloperidol 20mg daily*"
December 1997	Mild depression, anxiety and amphetamine dependence	Chlordiazepoxide Chlorpromazine Lofepramine Sertraline
August 1998	Mixed personality disorder	Unclear
March 1999	Mixed personality disorder with borderline and antisocial features	Unclear
May 1999	Personality disorder (dissocial with paranoid traits)	Depot flupentixol decanoate 40mg fortnightly Carbamazepine
October 1999	Psychopathic disorder	Depot flupentixol decanoate 40mg fortnightly Droperidol as required

Date	Diagnosis/legal category for detention	Medication
October 2000	Borderline personality disorder	Depot flupentixol decanoate 40mg fortnightly
May/June 2001	Psychopathic disorder	Quetiapine 300mg Sertraline 200mg Lorazepam as required Haloperidol as required
July to November 2002	-	Clozapine started in July This was gradually increased to 500mg by the end of November Zuclopenthixol 60mg Zuclopenthixol 40mg as required Diazepam 30mg as required
December 2002	Psychopathic disorder	Zuclopenthixol 60mg Diazepam 45mg as required Sertraline
January 2003	-	Chlorpromazine 400mg daily Zuclopenthixol 60mg Diazepam 45mg as required Sertraline
June 2003	**Severe** personality disorder with paranoid and borderline features	Chlorpromazine 400mg daily Sertraline
May/June 2004	**Severe** personality disorder with borderline, paranoid, dependent and antisocial features	Zuclopenthixol decanoate 600mg weekly Trifluoperazine 25mg Chlorpromazine 800mg daily Fluoxetine
October 2004	Paranoid schizophrenia Mixed personality disorder (dissocial and emotionally unstable – impulsive type	Unclear but the zuclopenthixol decanoate and chlorpromazine had been discontinued
April-June 2006	Mental illness and psychopathic disorder	Clozapine
May 2007	Mental illness and psychopathic disorder	
December 2007		Clozapine
April 2008	Mental illness (paranoid schizophrenia) and psychopathic disorder (personality disorder; antisocial and unstable type)	

Date	Diagnosis/legal category for detention	Medication
December 2008	Schizophrenia and personality disorder	Clozapine Valproate
March 2009	Schizoaffective disorder and borderline personality disorder	Clozapine 325mg Citalopram 20mg Valproate 2400mg
May 2009	Personality disorder – mixed dissocial and paranoid Polysubstance misuse	Clozapine 325mg
January 2010	Mixed dissocial and paranoid personality disorder	Depot 60mg (later increased to 120mg) Citalopram Sodium valproate 2400mg
March/April 2010	Mixed dissocial and paranoid personality disorder	Depot 120mg Clozapine re-started (at Mr P's request)
May 2010	Personality disorder	Flupentixol (off licence) – however this is different from the previous statement of clozapine being restarted
June 2010	Personality disorder	Aripiprazole (off licence and later stopped) Clozapine
April/May 2011	Personality disorder	Clozapine 300mg Valproate 2400mg Venlafaxine 225mg
January/ February 2012	Primary: paranoid schizophrenia Secondary: dissocial personality disorder	Clozapine (off licence)
June 2012	Personality disorder (long-standing) with associated psychotic symptoms	
September 2012	Mixed personality disorder	Clozapine 300mg (off licence)
April 2013	Schizophrenia Mixed personality disorder	Valproate
November 2013	Personality disorder with emotionally unstable and dissocial traits	Clozapine 300mg Sodium valproate 2400mg Venlafaxine 225mg
July 2014	Personality disorder History of paranoid psychosis	
January 2015	Personality disorder (No formal history of psychosis or any other form of mental illness)	

Use of clozapine

8.4 Mr P was first prescribed clozapine in 2002. Although the records are not clear, it appears that this was done on an 'off licence' (and short-lived) basis to try and treat symptoms of personality disorder. From 2006, Mr P was apparently confidently regarded as suffering psychosis, and clozapine was prescribed again by December 2007. It seems to us most likely that this was done in order to treat psychotic disorder, and we note that this was also Dr Y's clear view. After the diagnosis was reviewed in May 2009, the use and dose of clozapine continued unchanged. It was from this point once more that it was being prescribed 'off licence', and it was recognised by Mr P's team that its use had seemed beneficial for him.

8.5 General Medical Council (GMC) guidance for doctors who are prescribing medicines off licence is that the doctor must:

- *"be satisfied that there is sufficient evidence or experience of using the medicine to demonstrate its safety and efficacy;*
- *take responsibility for prescribing the medicine and for overseeing the patient's care, monitoring, and any follow up treatment, or ensure that arrangements are made for another suitable doctor to do so;*
- *make a clear, accurate and legible record of all medicines prescribed and, where you are not following common practice, your reasons for prescribing an unlicensed medicine."*

8.6 In addition, the GMC states that the doctor must give the patient sufficient information about the medicines in order for them to be able to make an informed decision about consenting to accept the medicine.

8.7 We have not been able to find any records describing a clinical discussion of this nature with Mr P. In fact, it seems clear that on several occasions Mr P asserted that he suffered from schizophrenia, and he may have believed that clozapine was being prescribed with this purpose in mind. See our Recommendation 4.

Paranoid schizophrenia

8.8 As we have noted above, the case summary that followed Mr P from Ravenswood House to the Trust in 2009 erroneously stated that Mr P's diagnosis had been unchanged since 1990. It also contained within it several gaps that covered much of his stay in Broadmoor (where his diagnosis had in fact been changed). We agree with Dr Y that this diagnostic issue got "*lost in translation*" when Mr P returned to St Ann's Hospital, and that this case summary formed the basis of the medical reports subsequently prepared whilst he was under the care of the Trust.

8.9 In 2012, Dr E1 was aware that Mr P had previously presented with "*symptoms consistent with paranoid psychosis*" and she reportedly told a Tribunal panel that view was "*that there is some form of psychotic illness also present*".

8.10 In November 2013, Dr S1 recorded that Mr P "*had a history of psychotic symptoms*" and that "*both disorders*" i.e. psychosis and personality disorder had "*responded to clozapine*". In a July 2014 report, Dr S1 also noted a history of both paranoid psychosis and a good response to antipsychotic medication. However, at interview Dr S1 told us that they had no knowledge or recollection of any previous or historic diagnosis of psychosis in Mr P's case. This is perhaps a demonstration of a more general theme that some historical clinical information about Mr P did not reliably follow him as he progressed through from high secure, medium secure, low secure and community settings. In effect, there was a leakage of information about past recorded psychotic symptoms (and the subsequent use of clozapine) and, overall, this aspect of Mr P's diagnostic formulation became generally less salient over time.

8.11 We do not know what Mr P's own view about this matter was and we have seen no records suggesting that this issue was ever discussed with him by Trust staff. However, we do note that on several occasions he at least asserted that he suffered from schizophrenia.

8.12 Dr S1 told us that where a diagnosis of psychosis is made, there is a greater expectation of intervention and responsibility on the part of the service, whereas with a diagnosis of personality disorder, there may be a greater expectation of personal responsibility being exercised by the person concerned.

8.13 For example, it is entirely possible that after reports of psychosis were made by Mr P to staff in A&E and to police officers earlier in 2016, their refutation by mental health staff significantly influenced the decision of those staff not to assess him in person, on the grounds that assessment would inappropriately reinforce his maladaptive help-seeking behaviours.

8.14 While it is of course impossible to be certain in retrospect, clarity within the service and records about the historic diagnosis of psychosis (made in a highly specialised, secure setting) and about the implication that psychosis should therefore always have been considered as a potential differential diagnosis, could well have led to the liaison service or diversion service, or both, taking rather different actions in response to the same presentation.

8.15 It is important to be clear that the actions we refer to here are assessment and professional curiosity regarding previously recorded apparent psychotic symptoms. Assessment was twice declined because clinical staff felt (without seeing him) that Mr P's behaviour reflected personality traits and that assessment would reinforce maladaptive behaviours. If Mr P's formulation had instead recognised that psychotic symptoms had been recorded (rightly or wrongly) previously, then it is possible that assessment would not have been refused on the same grounds. It is important to note here that our findings here are entirely consistent with Dr Y's findings set out in the internal investigation report where she said:

> *" …there is little evidence of structured mental state examinations being carried out, and I could find nowhere in the records where anyone at [the*

Trust] had asked [Mr P] directly about his previous symptoms … or discussed with him in detail his understanding of his diagnosis … no-one [explored] the psychosis issue in depth …"

"…Reviewing the notes of the CPA meeting on 10.08.16, I think there were grounds to consider such a formal [MHA] assessment …I think it could have been argued that an admission under Section 2 was warranted to further assess him … I think that the option of readmission was not given sufficient consideration …I also think that if the diagnosis of Schizophrenia had been recognised, this would have influenced the decision about the need for a hospital admission."

8.16 See our Recommendation 5.

Personality disorder

8.17 It appears to us that while Mr P was being treated in hospital in 2012, there was relatively little evidence of serious antisocial behaviours on his part, or of major emotional dysregulation, certainly when compared to his earlier presentations. Nevertheless, and as stated by Dr Y, if the team believed that Mr P did not have a history of psychosis then they would in general be less likely to consider that any different or new symptoms or behaviours might have been indicative of such a disorder.

8.18 Such an understanding may well have been correct, but where diagnostic formulations are incomplete or not fully comprehensive then the processes of assessment, understanding and management response or decision-making can then also be incomplete. For example, regular specific inquiries about potential (and recorded) psychotic symptoms might be incorporated into reviews of someone's mental state. In Mr P's case, it does not appear (from the records) that psychotic symptoms were directly asked about after 2013. Further, as Dr Y has previously noted, it is possible that "*when [Mr P] did have symptoms of mental disorder, the automatic assumption was that these symptoms related to his personality disorder - because the other diagnoses schizophrenia and PTSD [post-traumatic stress disorder]) were not recognised*".

8.19 We acknowledge that for a large proportion of Mr P's time within mental health services his diagnosis is confidently listed as personality disorder.

Post-traumatic stress disorder

8.20 Mr P made a significant disclosure to Broadmoor staff in March 2003, about historic abuse (page 45). Following this staff noted that Mr P's difficulties suggest that he may have been subjected to more extensive abuse as a child. The extended entry is, in our view, crucial in indicating that staff were not doubting or denying Mr P was abused (as opposed to the suggestion in Dr Y's report). Staff suggested that Mr P was under-reporting his abuse in that if he were being untruthful it was in the form of denying the extent of the victimisation, rather than exaggerating it, as was previously (and latterly)

suggested by Ravenswood House staff in relation to Mr P's description of his symptoms.

8.21 Mr P reported nightmares and experienced incontinence, and in our view these features could well have been post-traumatic in nature. Mr P was not offered specific therapy for post-traumatic stress disorder at Ravenswood House or whilst under the care of forensic services in Dorset (either as an inpatient or when he was in the community), despite this outstanding treatment being recognised as an unmet need.

8.22 NICE guidance for the treatment of post-traumatic stress disorder (for patients whose symptoms have been present for more than three months) states at 1.9.2.1 and 1.9.2.2:

> *"All PTSD sufferers should be offered a course of trauma-focused psychological treatment (trauma-focused cognitive behavioural therapy or eye movement desensitisation and reprocessing). These treatments should normally be provided on an individual outpatient basis.*
>
> *Trauma-focused psychological treatment should be offered to PTSD sufferers regardless of the time that has elapsed since the trauma."*

8.23 Mr P should have been offered appropriate therapy for his post-traumatic stress disorder symptoms. The consequences of ongoing, untreated post-traumatic stress disorder could have contributed to Mr P's inability to function normally.

8.24 See our Recommendation 6.

Use of a Community Treatment Order

8.25 The benefits of a Community Treatment Order are that a patient can leave hospital and be treated in the community but is required to comply with a treatment plan (medication and/or therapy) and other services. If the patient does not comply with any aspect of their treatment plan they can be recalled to hospital. This is often used to identify whether patients (particularly those who have been detained in hospital for a long time) are sufficiently stable to be able to look after themselves in the community.

8.26 Mr P was first released on a Community Treatment Order in September 2012, the conditions of his release included:

- abstaining from alcohol and illicit drugs and to submit to testing as required;
- attending appointments as reasonably requested;
- informing the treatment team of any planned trips outside of the Dorset area.

8.27 Mr P was recalled within six months (March 2013) because of his amphetamine use.

8.28 The second time Mr P was released on a Community Treatment Order was in November 2013. The conditions of his release on that occasion included:

- attending appointments with forensic team staff as requested;
- taking medication as prescribed;
- attending psychological treatment and occupational therapy appointments;
- abstaining from drugs and alcohol and submitting for testing as requested.

8.29 The Community Treatment Order was due to expire at the end of November 2014, and Mr P was discharged from the treatment order a few weeks beforehand. Although there were concerns about a lack of structured activity for Mr P, he appeared to be well enough to be able to be discharged from the Community Treatment Order.

8.30 When Mr P arrived back in Dorset in Spring 2016 he was showing signs of known risk factors that indicated he was unwell or becoming unwell:

- non-compliance with treatment (medication);
- non-engagement with staff (he did not attend the Care Programme Approach meeting and was only focussed on staff helping him to secure accommodation that he considered to be appropriate);
- social stress (he had experienced a breakdown in the "*idealised*" relationship with his son and had failed to evidence that he could be successful in independent living);
- substance misuse (he admitted he was using substances).

8.31 This combination of risk factors had previously been present when Mr P was recalled to hospital, yet in 2016 (in the absence of him being subject to any section of the Mental Health Act) the same risks were not associated with a comparable response.

Pathfinder service

8.32 The forensic community Pathfinder service works with patients who have a diagnosed personality disorder and are at risk of offending. The aim of the services is to improve patients' outcomes and at "*significantly lower cost than being in hospital*" (as quoted in a report to the Trust Board in March 2016).

8.33 Mr P received treatment from the Pathfinder project team. This was essentially additional psychology resources for patients under the care of the community forensic service. Dr S1 told us that Mr P's treatment from the Pathfinder team ended in (date) "*when he [Mr P] ran out of treatment goals*".

8.34 Dr J2 told us that whilst Mr P was an inpatient at St Ann's Hospital the psychology team prioritised the work that they did, because they did not have

the capacity to provide treatment to everyone that needed it. Dr J2 said that she recalled that Mr P's "*over-riding vision of his future*" was to stay with his son.

Risk assessments

8.35 Mr P's recognised relapse risk factors had been identified by the clinical team in Dorset as:

- non-compliance with treatment (medication);
- non-engagement with staff;
- social stress;
- substance misuse;
- poor physical health.

8.36 The clinical team in Cornwall had identified his relapse indicators as:

- paranoia;
- external voices;
- frustration;
- drug abuse;
- making complaints;
- avoiding interaction with staff;
- physical health worries.

8.37 We have not seen a copy of an HCR-20 completed at either Broadmoor or Ravenswood House, despite the fact that one is referred to several times in the Ravenswood House clinical records. At a case review at Ravenswood House in May 2009 it is recorded that an HCR-20 was to be completed within six months. The case summary in May 2011 stated that an HCR-20 would be updated in future. There is a document entitled risk assessment that has a section titled HCR-20 but it does not use the HCR-20 format and makes no mention of a past diagnosis of psychosis.

8.38 In March 2016, whilst still in Cornwall, members of the public called an ambulance because they were concerned about Mr P who was expectorating and hyperventilating. Mr P told the ambulance crew that his actions were his coping mechanism and that he was afraid of dying because he had been severely ill with pneumonia two years previously. This incident was reported to Mr P's GP, but the information was never shared with the mental health

team in Cornwall and therefore the mental health team in Dorset was also unaware of the incident.

8.39 An HCR-20 V3 was updated by the clinical team in Dorset in January 2015. The team relied upon the same document when Mr P returned to Dorset from Cornwall in spring 2016. This is of concern to us because by this time the document was 18 months old. Since the document had been completed 18 months earlier, Mr P had experienced a major change in his living arrangements, a bereavement, and a breakdown in his idealised relationship with his son. The document states that Mr P had no history of mental illness (a matter that was incorrect at the time of writing and 18 months later) and the scenario planning was completely out of date.

8.40 Mr P only registered as a temporary resident with a GP in Dorset after he returned from Cornwall in April 2016. This meant that Mr P's full GP records were not transferred from the surgery in Launceston, thereby the opportunity for information about the incident above was lost. It remains unclear to us why Mr P was registered only as a temporary resident when he had made it clear that he did not intend to return to Cornwall.

8.41 Dr S1's final letter to Mr P's GP was dated 15 August 2016 and was sent following the Care Programme Approach meeting held on 10 August. Dr S1 noted Mr P's current risk of suicide and current risk of harm to others to be "*significant*". Despite this view, Dr S1 refused to admit Mr P to hospital when he was not compliant with his medication, had presented to A&E complaining of feeling mentally unwell, was using illicit drugs and alcohol and was homeless. All these were risk factors listed as indicators that Mr P was becoming very unwell. Admission should have been more properly or formally considered, and if the diagnostic formulation had been more comprehensive this might have happened.

8.42 It is our opinion that when Mr P presented back in Dorset in the summer of 2016, his presentation had some parallels with his presentation in March 2013 when he was recalled from his Community Treatment Order. It appears that there was a very different approach to Mr P's risks in summer 2016.

8.43 His return to Dorset was a check point when the Dorset team could have treated Mr P's re-referral as a new referral into the team. This could have provided opportunity to fully review all of the available information about Mr P's mental health history, and an assessment in accordance with the team policy at the time. We consider that this was a missed opportunity.

Presence of "Hans Blood"

8.44 Mr P referred to "*Hans Blood*" (intermittently but many times) during his treatment, from as early as 1998 and usually when his mental state was more disturbed. This, together with other recorded symptoms such as persecutory beliefs, thought alienation experiences (a group of experiences where a person's thoughts are not entirely their own thoughts and appear to be alien to the individual.

8.45 There is little evidence that community staff in Dorset sought to understand how and why "*Hans Blood*" featured in Mr P's descriptions nor (particularly when he was unwell or becoming unwell) a curiosity to know whether "*Hans Blood*" was present in Mr P's thoughts at that time.

Accommodation

8.46 Mr P was living in 24-hour supported accommodation at Leven House when he was first discharged into the community in September 2012. This meant that Mr P had support staff available to help his transition into the community, the first time he had not been detained in an institution in nearly 14 years. As we have previously stated Mr P did not comply with the conditions of his licence and therefore was recalled to hospital.

8.47 When Mr P was discharged from St Ann's Hospital in November 2013 he was again living in 24-hour supported accommodation, this time at Northover Court. This appeared to work well, and plans were made for Mr P to move to an annex of the supported accommodation, offering him the opportunity of greater independence.

8.48 Mr P had always been clear that his wish was to move to Cornwall to be close to his son. The clinical team were working towards this, but not at a speed that was acceptable to Mr P. Thus, in June 2015 Mr P moved to Cornwall after having told his clinical team that he had found a room in a flat in Launceston and have given notice on his flat at Northover Court.

8.49 It is clear from the information that he gave to the staff at a meeting in May 2015 that the occupier of the flat was his son, but this is not referenced in the minutes of the meeting. It is possible that none of the staff present at that meeting recognised Mr P's son's name, it is also possible that Mr P deliberately did not mention this point because there had been previous discussions about the risks of Mr P living with his son.

8.50 Mr P lived with his son for a number of weeks but did eventually secure his own flat. There were difficulties between Mr P and another tenant in the building that resulted in clinical staff in Cornwall intervening with the landlord on Mr P's behalf. It was whilst Mr P was living completely independently that his mental health declined. Mr P was attacked and, it appears, fled back to Dorset to escape.

8.51 On return to Dorset there was a great amount of attention given to trying to secure Mr P accommodation of his own. Mr P was considered to have made himself intentionally homeless, because he had given notice on his accommodation in Dorset the previous year and had subsequently left his flat in Cornwall. Attempts to secure bed and breakfast accommodation were hampered by the fact that it was the summer and many bed and breakfasts were full with bookings from tourists. In addition, Mr P had refused to pay towards any accommodation claiming he had no funds to do so, despite it appearing later that he had in excess of £600 available.

8.52 It is clear to us that the lack of accommodation exacerbated Mr P's mental health problems, but it is not our view that this issue was the cause of his mental health problems.

MAPPA (Multi agency public protection arrangements)

8.53 Mr P was first discussed at a MAPPA meeting on 6 July 2010 when it was Mr P's MAPPA Level was set. At that time, he was described as a "*Level 1*" case.

8.54 A MAPPA registration form was completed on 15 July 2010. This provided details of Mr P's offence (threats to kill – two offences), the date of his conviction (1 October 1998) and his sentence (Section 37 Mental Health Act).

8.55 A MAPPA offender profile form completed on 1 October 2010 noted that Mr P was a "*Category 2*" offender. This meant that he was classed as a violent offender.

8.56 There are three levels of MAPPA management. They are mainly based upon the level of multi-agency co-operation required with higher risk cases tending to be managed at the higher levels. Mr P was therefore considered to be a lower risk case at this time which would put him as a Level 1 case.

8.57 The MAPPA guidance states that a Level 1 case can be managed by the organisation responsible for the supervision or case management of the individual. However, this does not mean that other agencies will not be involved, only that it is not considered necessary to refer the case to a Level 2 or Level 3 meeting. Information sharing is described as being essential, and that disclosure to third parties with significant contact with the individual should be considered and discussed between agencies as necessary. Importantly the guidance is clear that organisations must review an individual in accordance with their own policies and procedures.

8.58 Mr P was discussed at a MAPPA meeting on 21 December 2010 when it was noted that he was detained in a secure hospital, had no impending prosecutions and there was no new intelligence on him. The review form completed following the discussion does not indicate whether or not Mr P was to remain on Level 1 (we assume that he did given the outcome of the following MAPPA meeting) but it did note that the next review would take place on 21 June 2011.

8.59 Mr P was discussed at a MAPPA meeting on 23 June 2011. Mr P was still described as a Level 1 case. It was noted that the next Level 1 review would take place on 22 December 2011 however we have not been provided with any records for that meeting. The next document is dated after Mr P was sentenced for Mr Merna's homicide.

8.60 Following Mr Merna's death, as part of the fact finding conducted by the Dorset Adult Safeguarding Board, the National Probation Service confirmed that Mr P had not been known to them at any time. We are surprised by this

given that Mr P's list of offences included two separate counts of arson and firearms offences.

8.61 We can find no other references to Mr P being discussed at MAPPA meetings and have not been able to understand why this was the case.

8.62 It is unclear, therefore, why there was no notification to the MAPPA meeting prior to Mr P's move to Cornwall. There is no indication that Cornwall services were ever informed that Mr P had been subject to MAPPA management.

8.63 The MAPPA discussions appear to have simply stopped, with no conclusion or clarity about which agency was responsible for managing Mr P's ongoing risks (given that it appeared he remained a MAPPA Level 1 individual). Had there been clarity at this point, it might have prompted the Dorset team to consider MAPPA issues when Mr P moved to Cornwall.

8.64 However, the MAPPA guidance states that if a patient has received a hospital order, mental health services are the lead agency. Mr P's MAPPA status should therefore have been referenced in his mental health records when he was transferred to Dorset from Ravenswood because mental health services would have remained the lead agency. Further, when a patient is no longer subject to MAPPA supervision, the MAPPA guidance states that the Responsible Clinician should complete the relevant MAPPA form and forward it to the MAPPA coordinator. We found no evidence that this was completed.

8.65 There were potentially two key decision points when Dorset could have liaised with MAPPA agencies about Mr P, namely when he was discharged from hospital (on to a community treatment order) and when he moved to Cornwall. This would have been good practice, but we acknowledge it is not legally mandatory. The national guidance states these are "*opportunities*" for health organisations to communicate about Level 1 cases rather than being compulsory occasions to share information.

8.66 See our Recommendation 7.

Communication between NHS organisations

8.67 As we have stated elsewhere, responsibility for Mr P's care and treatment was transferred between inpatient units or community teams on nine occasions during the 20 years of care and treatment that we have reviewed. On five of those occasions the transfer was also a transfer to a different organisation.

8.68 Communication between units and organisations appears generally to have been in accordance with best practice. However, there are essential pieces of information that are missing from key documents that result in future clinical teams' lack of understand of the importance, or indeed awareness at all, of that information.

8.69 Key examples of missing information include:

- A case summary completed in June 2009 by a junior doctor at Ravenswood House stated that Mr P's diagnosis of personality disorder had been unchanged since 1990. There was no mention of the diagnosis of schizophrenia made by the clinical team at Broadmoor.

- Dr S1's lack of awareness that Mr P had been given a diagnosis of paranoid schizophrenia, despite the fact that he had written and signed two reports (in November 2013 and in July 2014) that Mr P had a history of psychotic symptoms or paranoid schizophrenia.

- A general lack of awareness amongst healthcare staff in Dorset of Mr P's previous diagnosis of schizophrenia, resulting in advice to A&E staff that Mr P's self-reported previous diagnosis of schizophrenia be ignored.

8.70 See our Recommendation 8 and our Recommendation 9.

8.71 Services in Cornwall did not provide the services in Dorset with a detailed summary of Mr P's presentation whilst living in Cornwall. This meant that the Dorset Forensic Team staff were not aware of the difficulties Mr P had encountered in independent living, nor the fact that he had not been taking his medication. Had there been a formal handover at the point that it was clear to services that Mr P would not be returning to Cornwall, this process would have provided the opportunity for relevant and updated information to be shared. See our Recommendation 11.

Service response after April 2016

8.72 By late April 2016 Mr P was known to be back in Bournemouth, and on 17 May he was formally discharged by Cornwall services. By 19 May, he was accepted back onto the caseload of the forensic team in Dorset. This happened without the forensic team processing a formal referral from Cornwall, and the actions did not follow the forensic team's own operational policy for assessing referred patients.

8.73 Dr S1 told us that bearing in mind that Mr P's history and service contact, it would have been unreasonable to delay Mr P's access to treatment by expecting other agencies to hold the case while a formal referral was processed. This appears to us to be a clinically sensible view.

8.74 Dr Y (the internal report author) suggested that the subsequent decision not to undertake a fresh review and reformulation of Mr P's case represented a missed opportunity to look back and, potentially, to re-consider diagnosis. Dr S1's view was that a full review was not necessary, and that the clinical priority was more an urgent action to stabilise Mr P's circumstances and to put in place a clinical team around him.

8.75 By the time Mr P returned to Dorset from Cornwall he had been known to the forensic team in Dorset for more than four years (two of which Mr P had been in the community), and no 'retrospective' or thorough review had been undertaken during this period.

8.76 The importance of ensuring that care is taken in sharing clinical data and risk-relevant information on the first occasion that it is transferred is crucial, as mentioned above.

8.77 During the period June to August 2016 forensic team staff in Dorset made repeated efforts to secure accommodation for Mr P, despite repeated incidents of his truculence, lack of co-operation and lack of engagement.

8.78 On 27 May, Mr P told staff he would harm himself if he was not offered accommodation, and on 31 May he complained that no-one was helping him and everyone had let him down.

8.79 On 3 June, he said he would get admitted via the police or crisis team. Yet when he was taken to A&E by the police on 4 June, the psychiatric liaison team concluded that there was no role for an assessment as this would reinforce his inappropriate behaviour designed to gain mental health services support (specifically, admission to hospital).

8.80 A short time after, a criminal justice nurse refuted (to a police officer) Mr P's self-reported diagnosis of schizophrenia and agreed that assessment was inappropriate as it would "*reinforce his behaviour in seeking accommodation*". The nurse does not comment about Mr P's self-reported diagnosis other than to state it was incorrect - it is possible they believed that this claim was merely part of his accommodation seeking behaviour, rather than potentially being an understandable and sincerely held belief.

8.81 If the available records had indicated that psychosis was a past, and potentially current, diagnosis, then it is possible that the two decisions to decline assessment might not have been made so that it could be established whether Mr P was experiencing psychotic symptoms at that time.

8.82 We have already noted above that Mr P had not been asked about psychotic symptoms for several years while under the care of the forensic team in Dorset and it is not possible to know with any certainty what might have happened if he had been.

8.83 Mr P's presentation at A&E draws into sharper focus one of the specific ways in which service response might have been affected by diagnostic considerations. Mr P's presentation was assumed to be inappropriate care-seeking behaviour without any assessment, and indeed was assumed to be behaviour which would be further reinforced should any assessment be undertaken. In other words, assessing the patient was considered by staff at the time to be both unnecessary and counter-productive.

8.84 It is hard to conclude that either assumption would have been as likely to have been made were Mr P regarded as having a history of a psychotic disorder, rather than, or as well as a personality disorder. If, as Dr S1 told us, the potential for psychotic symptoms may carry with it a greater responsibility and lower threshold for action on the part of services, then conducting a face-to-face assessment might have been more likely to have been considered.

8.85 It is documented in Mr P's records, and confirmed to us by staff, that despite being formally homeless Mr P did not appear unkempt. Indeed, he appeared to have good personal hygiene and was frequently wearing clean clothes.

8.86 It was believed that Mr P was staying with a friend or friends. It was noted that as late as 8 July, despite his circumstances, Mr P was generally upbeat, denying symptoms and seeming well in himself and relaxed. On the other hand, a number of risk factors recognised as part of Mr P's care planning, were known to be present:

- social stressors;
- drug use;
- relationship instability;
- disengagement and non-compliance.

8.87 Mr P's relationship with his son had broken down (having been regarded by staff previously as a worryingly idealised relationship), and he had learned a second son had died. He was homeless, using drugs and unhappy about services, the latter was often an indicator of his deteriorating mental state. There were doubts about medication (clozapine) compliance, and he had quickly disengaged with Cornwall services. These factors became more pronounced in the few weeks before Mr Merna's death.

8.88 On 26 July, it was recorded that Mr P had recently escalated threats of self-harm, and on 27 July he said he was "*feeling cold, tired and missing medication because of the chaotic way he is living. He responded positively to suggestion of a tent and warm bedding*".

8.89 On 28 July, it was noted that Mr P reported he was sleeping in bushes near Northover Court, and that forensic team staff had noted: "*a slow decline in his ability to cope and in his physical well-being … is increasingly expressing the urge to self-harm and feeling hopeless*".

8.90 In early August, it was noted that Mr P had been:

- "*playing around with his medication*", and not always been taking it as prescribed;
- smoking cannabis;
- noted as being covered in scratches;
- noted as being unshaven and had a facial bite mark.

8.91 At a forensic team meeting on 9 August it was recorded that Mr P was "*becoming a little unwell"*. It was felt that he was becoming increasingly low and that he needed to be accommodated as soon as possible. When Mr P was reviewed by Dr S1 on 10 August, it was noted that his physical health

was poor, he felt hopeless and low, he was not compliant with his medication, and suicide and harm to others were considered as risks. It was recognised that risks were increasing, and that the housing situation was urgent. However, Dr S1 also described Mr P as '*well in his mental state'*, and that he had indicated he would self-harm if he was not accommodated. Dr S1 told us that, "*Certainly the three times I saw him after he came back, he seemed quite normal … I wasn't really that worried about him"*.

8.92 Repeated efforts to secure accommodation for Mr P continued throughout Friday 12 August 2016. Dr S1 told us that on that date, the social worker Ms C9 told him that the bleep holder had suggested to Ms C9 that Mr P be admitted to Twynham ward. Dr S1 told us he understood that Ms C9 had not indicated to him that she thought that Mr P should be admitted, and he stated that she had not asked for him to be admitted. Further, he told us, even if she had asked, his answer would have been the same, the threshold for admission had not in his view been reached.

9 Conclusions and recommendations

9.1 Mr P was consistently given a diagnosis of personality disorder, with polysubstance misuse, over a period of more than twenty years. The specific personality disorder diagnoses made in Mr P's case have generally been of a 'mixed' picture, especially relating to antisocial (or dissocial) and borderline (or emotionally unstable) traits, and also paranoid and dependent traits.

9.2 Mr P was also diagnosed with paranoid schizophrenia whilst he was detained in a high secure hospital. He was prescribed clozapine and there are many reports that state that he responded well to this treatment. His diagnosis of paranoid schizophrenia was not supported by his new clinical team within a short time of his transfer to Ravenswood House (in fact, while he was still on trial leave, and so technically a Broadmoor patient for the purposes of the Mental Health Act).

9.3 There was strong evidence of significant, early onset and persistent difficulties, with a reported history of destructive, abusive, aggressive, violent and other antisocial behaviour in childhood. The self-reported history of sustained neglect by his father, cruelty and physical violence, and of sexual assault and victimisation during early adolescence, is compatible with such difficulties.

9.4 Mr P's presentation from late adolescence onwards clearly indicated longstanding difficulties in interpersonal relationships (including with carers, and concerns about abandonment) and in regulation of mood and arousal, as well as sensitive and paranoid traits and impulsivity. Notably, there was a significant history of criminality from early adolescence onwards, including violent offending, use of weapons (knives), and access to firearms, as well as recorded deliberate self-injury and deliberate self-poisoning.

9.5 In addition, Mr P regularly reported previous and current alcohol or illicit drug misuse. Substance misuse and alcohol misuse were noted from the age of 13 years, including alcohol withdrawal symptoms at aged 16 years. Mr P has reported heavy use of cocaine, amphetamine and MDMA no later than 1987, alongside substance misuse.

9.6 Mental health professionals had repeated concerns about drug-seeking and drug-taking behaviour at several points during his long period as an inpatient, and then during his time in the community.

9.7 What we believe to be most important here is not specifically whether Mr P met the criteria for personality disorder, or psychosis, or both, but rather the processes by which clinical data relating to these diagnostic issues followed Mr P along his care pathway, and how it was available to and used by the clinicians involved in his care. The key reason why this 'data flow' is important is that diagnostic issues of this sort can affect how practitioners and services respond to patients and clinical scenarios, including when assessing and formulating risk and its management.

9.8 Given Mr P's history, and the recognised ongoing presence of known clinical risk factors, we conclude that his attendance at A&E on 4 June 2016 represented an opportunity for a formal, multi-disciplinary discussion about his management, possibly (but not necessarily) amounting to a formal Mental Health Act assessment.

9.9 A more detailed, complete and consistent diagnostic formulation regarding Mr P by the forensic team in Dorset could have had a significant impact on the degree to which assessment and management of clinical risk was comprehensive and robust. It is clear from Trust records and our interviews with staff that the team in Dorset considered his presentation to entirely reflect personality traits (sometimes confounded by substance misuse).

9.10 We acknowledge that a diagnosis of personality disorder had been exclusively ascribed since 2009. However, there is no evidence that staff reviewed (or were sufficiently aware of) the history that for several years up to 2009 psychotic disorder had also been confidently diagnosed and treated. Nor is there evidence that staff then considered whether Mr P's presentation (including adverse behaviours) might be linked to psychotic symptoms or relapse. Had this happened, we believe that clinical responses could have been different - for example, in terms of structured mental state examination, and around attributions attached to particular behaviours or symptoms.

9.11 Regarding the way in which Mr P was accepted back onto the team's caseload without a multi-disciplinary review, we believe this was a further missed opportunity for a formal discussion and recording of clinical perspectives. Had this taken place it would have ensured that any key decision (whether different or not) would be more robustly informed and assured. The absence of a multi-disciplinary team review meant that the opportunity for any management plan to be more comprehensively informed and assured was impaired.

9.12 Finally, we also believe that had steps been taken by the clinical team to ensure they had a more comprehensive and detailed awareness of how the issues of presentation, diagnosis (especially around documented psychotic symptomatology) and treatment response had developed and been responded to by previous services, it is likely that they would have been able to develop a more nuanced and complex formulation of Mr P's presentation and behaviours. Following on from this, it is then at least possible that the processes of decision-making, and the events flowing from these, would have unfolded differently. For example, in comparable circumstances but where a differential or supplementary diagnosis of schizophrenia was not excluded, a team might be more likely to give greater consideration to structured clinical examination and to the issue of whether a Mental Health Act assessment was clinically indicated.

9.13 We cannot say with certainty that decisions and outcomes would necessarily have been different, but in a service where important clinical information is not properly available, it is more likely that clinical decision making is less informed and less robust.

Predictability and preventability

9.14 As part of our terms of reference we have been asked to consider whether this incident could have been predictable or preventable.

9.15 Predictability is "the quality of being regarded as likely to happen, as behaviour or an event".[46] An essential characteristic of risk assessments is that they involve estimating a probability. If a homicide is judged to have been predictable, it means that the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it.[47]

9.16 Prevention[48] 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 be the knowledge, legal means and opportunity to stop the incident from occurring.

9.17 Despite the level of concerns being expressed about the increase in Mr P's risks on Friday 12 August 2016, it is our view that the clinical team treating Mr P could not have predicted that he would kill Mr Merna that weekend.

9.18 There is good evidence that Mr P's mental state was declining or was at least less robust. He was regarded as not reliably compliant with medication, was expressing acute frustration, had no stable accommodation, and was showing evidence of physical and mental deterioration. His risks at that time were considered to be significant.

9.19 In general, when patients with complex presentations (including a history of serious violence) display a deterioration in their mental state, or are at risk of relapse, and are not admitted to hospital within a reasonable timeframe, there will overall be an increased likelihood of serious incidents. In Mr P's case, it is in our view that it is possible that a more fully informed diagnostic formulation could have led to a different service response, and that this could have included a more formal review of his mental state and discussion of the option of hospital admission.

9.20 While accepting that this must be speculative in nature, we agree with Dr Y that in the context of a more comprehensive formulation, it is possible that decision making around hospital admission (including formal detention) might have been materially influenced. We cannot conclude, however, that even in such circumstances an admission would have been offered - or that a declined offer would have been followed by detention under the Mental Health Act. It is our view that Mr Merna's death was not preventable.

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[46] *http://dictionary.reference.com/browse/predictability*

[47] *Munro E, Rumgay J, Role of risk assessment in reducing homicides by people with mental illness. The British Journal of Psychiatry (2000)176: 116-120*

[48] *http://www.thefreedictionary.com/prevent*

Recommendations

9.21 This independent investigation has made recommendations for the Trust, the NHS Dorset Clinical Commissioning Group, agencies involved in managing individuals through MAPPA and NHS England to address in order to further improve learning from this event.

9.22 The recommendations have been given one of two levels of priority:

- **Priority One:** the recommendation is considered fundamental in that it addresses issues that are essential to achieve key systems or process objectives and without which, the delivery of safe and effective clinical care would, in our view, be compromised.

- **Priority Two:** the recommendation is considered important in that it addresses issues that affect the ability to fully achieve all systems or process objectives. The area of concern does not compromise the safety of patients but identifies important improvement in the delivery of care required.

Priority One

Recommendation 1

The Trust must ensure that all serious incident reports comply with all of the standards set out in the NHS England Serious Incident Framework so that:

- root causes to incidents are clear in cases where they are identified;
- appropriate learning can be identified and shared;
- findings can be shared in an open and transparent way with affected parties.

Recommendation 2

The NHS Dorset Clinical Commissioning Group must ensure that provider serious incident reports comply with all of the standards set out in the NHS England Serious Incident Framework, that there is an audit trail of assessment of serious incident reports, and that appropriate action is taken when this is not the case.

Recommendation 5

The Trust must ensure that the forensic team is clear about all current and previous diagnostic formulations, particularly where there have been substantial periods of care in multiple settings, in order to ensure that assessment and treatment plans are relevant and appropriate.

Recommendation 7

Agencies involved in managing individuals through the MAPPA process must ensure that information about risks and management of those risks is passed to other areas when an individual moves to the jurisdiction of another MAPPA group. The Trusts involved in this case must review their existing MAPPA policies with this recommendation and associated findings in mind.

Recommendation 8

NHS England must ensure that secure services provide all relevant clinical information within progress reports, correspondence and discharge documents so that future clinical teams have a complete picture of a patient's diagnosis, risk and treatment history.

Recommendation 9

The Trust must also ensure that HCR-20's (risk assessments) are kept up to date with relevant information, particularly when responsibility for the patient's care and treatment is being transferred from another provider.

Recommendation 10

The Trust must ensure that all communications executing their Duty of Candour responsibilities (including when acting in the spirit of Regulation 20) fulfils all of the requirements of the Regulation.

Recommendation 11

Cornwall Partnership NHS Foundation Trust must ensure that when a patient is discharged to the care of an originating team a full summary of the patient's care and treatment whilst in Cornwall is provided to the receiving team.

Priority Two

Recommendation 3

The NHS Dorset Clinical Commissioning Group must ensure that:

- provider action plans properly address recommendations in the associated serious incident reports;
- provider action plans are appropriately monitored, and that evidence is assessed to provide assurance that the required actions are in place;
- when actions are not completed within the agreed timeframe, the provider is required to explain the delay.

Recommendation 4

The Trust must ensure that patients are provided with appropriate information about medicines in order for them to be able to make an informed decision about consenting to accept the medicine. This is even more important when a medicine is prescribed off licence.

Recommendation 6

The Trust and its commissioners must ensure that the relevance of previous post-traumatic stress disorder diagnoses and of potential current post-traumatic stress disorder symptoms should be routinely considered, and appropriate guidance followed where relevant.

Appendix A - Terms of reference for the independent investigation

The terms of reference were finalised by NHS England but a further copy was not circulated. At the initiation meeting NHS England confirmed that the review of Mr P's care and treatment should be reviewed covering a period of 20 years, dating back to before he was admitted to Broadmoor.

Independent investigation into the care and treatment of Mr P by Dorset Healthcare University NHS Foundation Trust

Purpose of the investigation

To identify whether there were any gaps, deficiencies or omissions in the care and treatment that Mr P received, which, had they been in place, could have predicted or prevented the incident. The investigation should identify opportunities for learning and areas where improvements to local, regional and national services are required that could prevent similar incidents from occurring.

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

Terms of Reference

NB: The following Terms of Reference remain in draft formal until they have been reviewed at the formal initiation meeting and agreed with the families concerned. Dorset Healthcare University NHS Foundation Trust has commissioned an independent, level 2 investigation following the incident on 14.08.16. This investigation will build on that review in the following areas:

a. Review communication and liaison between Cornwall Partnership Trust and Dorset Healthcare University NHS Foundation Trust at the time that Mr P relocated to Dorset.

b. Review the quality of the longitudinal risk assessments in place for Mr P at the time of the incident, with particular reference to risk to others.

c. Review the quality of the treatment/care plans in place for Mr P at the time of the incident, with particular reference to the range of diagnosis described in the level 2 reports.

d. Determine whether there were any missed opportunities to engage other services and/or agencies, in particular Housing providers, to support Mr P and manage any presenting risks for example MAPPA or vulnerable adult processes.

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

f. If the investigations satisfied their own terms of reference.

g. If all key issues and lessons have been identified and shared.

h. Whether recommendations are appropriate, comprehensive and flow from the lessons learnt

i. Review progress made against the action plans

j. Review processes in place to embed any lessons learnt and any evidence to support positive changes in practice

k. Review the CCGs oversight of the resulting action plan.

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

m. To review and comment on Dorset Healthcare University NHS Foundation Trust and the CCGs enactment of the Duty of Candour.

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

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

p. To assess and review any contact made with the families involved in this incident.

q. To review the Trust's family engagement policy for homicide and serious patient incidents, measured against best practice and national standards.

r. Assist the family in the production of an impact statement for inclusion in the final published report, if appropriate

Timescale

The investigation process starts when the investigator receives all the clinical records and the investigation should be completed within six months thereafter

Initial steps and stages

NHS England will:

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

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

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

Outputs

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

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

x. A chronology of Mr Ps mental health and forensic history.

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

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

aa. Meetings with the victim and perpetrator families and the perpetrator to seek their involvement in influencing the terms of reference, to answer any questions relevant to the investigation process and scope.

bb. At the end of the investigation, to share the report with the Trust and meet the victim and perpetrator families and the perpetrator to discuss the findings of the investigation and engage the Clinical Commissioning Group with these meetings where appropriate.

cc. A concise and easy to follow presentation for families.

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

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

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

Other

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

hh. Should the family formally identify any further areas of concern or complaint, about the care received or the final report, the investigation team should highlight this to NHS England for escalation and resolution at the earliest opportunity.

Appendix B – Documents reviewed

Dorset University Hospital NHS Foundation Trust documents

- Clinical records
- Internal investigation report
- Notes from internal investigation interviews
- Action plan
- Timeline of how the internal investigation report was commissioned
- Serious incident investigation policy
- Operational policy for St Ann's Hospital
- Operational policy for Dorset Forensic Team
- Clinical risk policy
- Safeguarding adults policy pan Dorset
- Post-traumatic stress disorder pathway
- Being open (Duty of Candour) policy
- Care Programme Approach policy
- Follow up on discharge or transfer from mental health inpatient units policy
- Forensic inpatient service Twynham Ward operational policy
- Haven ward intensive care operational guidance
- Operational guidance for Seaview Ward
- Risk assessment policy
- Risk management policy
- Safeguarding adults policy
- Transfer of patients within community health services

Other documents

- Clinical records from West London Mental Health NHS Foundation Trust
- Clinical records from Southern Health NHS Foundation Trust
- Clinical records from Cornwall Partnership NHS Foundation Trust
- GP records

Appendix C – Professionals involved

Cornwall Partnership NHS Foundation Trust Staff		
Pseudonym	**Role**	**Team**
Dr R1	Consultant forensic psychiatrist	Cornwall Centre For Mental Health Justice
Mr M1	Social worker	Cornwall Centre For Mental Health Justice
Ms D1	Community mental health nurse	North Cornwall Integrated CMHT
Ms D2	Forensic community mental health nurse	Cornwall Centre For Mental Health Justice
Ms D5	Community mental health nurse	Cornwall Forensic Team
Ms P1	Community mental health nurse	Integrated Community Mental Health Team

Dorset University Hospitals NHS Foundation Trust Staff		
Pseudonym	**Role**	**Team**
Dr B1	Consultant forensic psychiatrist	Twynham Ward, St Anne's Hospital
Dr B2	Consultant clinical & forensic psychologist	Dorset Forensic Team
Dr E1	Consultant forensic psychiatrist	Dorset Forensic Team
Dr E2	Junior doctor	Dorset Forensic Team
Dr J1	Clinical psychologist	Dorset Forensic Team
Dr L1	Consultant psychiatrist	Dorset Health Care Trust
Dr L2	Clinical psychologist	Pathfinder service
Dr M5	Junior doctor	St Anne's Hospital, Poole
Dr N	Junior doctor	Dorset Forensic Team
Dr N3	Consultant psychiatrist	Dorset Forensic Team
Dr O	Junior doctor	Dorset Forensic Team
Dr S1	Consultant forensic psychiatrist	Dorset Forensic Team
Dr S2	Junior doctor	Dorset Forensic Team
Mr A2	Integrated service manager	St Anne's Hospital
Mr A3	Community mental health nurse	Dorset Forensic Team
Mr C1	Community mental health nurse	Dorset Forensic Team
Mr K1	Senior forensic community mental health nurse	Dorset Forensic Team
Mr N1	Social worker	Dorset Forensic Team
Mr N2	Community mental health nurse	Dorset Forensic Team
Mr P2	Community mental health nurse	Dorset Forensic Team
Ms B4	Senior social worker	Dorset Forensic Team
Ms C2	Assistant psychologist	Dorset Forensic Team
Ms C3	Community mental health nurse	Twynham Ward

Dorset University Hospitals NHS Foundation Trust Staff		
Pseudonym	**Role**	**Team**
Ms C4	Staff nurse	Dorset Health Care Trust
Ms C9	Social worker	Dorset Forensic Team
Ms D6	Community mental health nurse	Dorset Forensic Team
Ms N1	Community mental health nurse	Dorset Forensic Team

Leven House Staff		
Pseudonym	**Role**	**Team**
Mr K3	Member of staff	Leven House
Ms L2	Manager	Leven House

Probation Staff		
Pseudonym	**Role**	**Team**
Mr R1	Probation officer	Dorset Probation Service

Southern Health NHS Foundation Trust Staff		
Pseudonym	**Role**	**Team**
Dr A1	Consultant forensic psychiatrist	Ravenswood House
Dr A2	Junior doctor	Ravenswood House
Dr A5	Junior doctor	Ravenswood House
Dr B3	Consultant forensic psychiatrist	Ravenswood House
Dr B4	Junior doctor	Ravenswood House
Dr M1	Consultant forensic psychiatrist	Ravenswood House
Dr M4	Junior doctor	Ravenswood House
Dr S6	Junior doctor	Ravenswood House
Dr V	Junior doctor	Ravenswood House
Mr M2	Mental health nurse	Ravenswood House
Mr N3	Mental health nurse	Ravenswood House
Ms B3	Assistant psychologist	Ravenswood House
Ms K4	Senior occupational therapist	Ravenswood House
Ms L3	Music therapist	Ravenswood House
Ms L4	Social worker	Ravenswood House
Ms P3	Consultant clinical psychologist	Ravenswood House
Ms S2	Forensic social worker	Ravenswood House

West London Mental Health NHS Foundation Trust Staff		
Pseudonym	**Role**	**Team**
Dr A3	Consultant forensic psychiatrist	Broadmoor Hospital
Dr D1	Junior doctor	Broadmoor Hospital
Dr G1	Consultant forensic psychotherapist	Broadmoor Hospital
Dr M3	Junior doctor	Broadmoor Hospital
Dr N2	Junior doctor	Broadmoor Hospital
Dr S4	Consultant forensic psychiatrist	Broadmoor Hospital
Dr S5	Consultant forensic psychiatrist	Broadmoor Hospital
Mr A1	Forensic social worker	Broadmoor Hospital
Ms C6	Forensic social worker	Broadmoor Hospital
Ms C7	Social worker	Broadmoor Hospital
Ms J2	Senior forensic social worker	Broadmoor Hospital
Ms Y1	Forensic social worker	Broadmoor Hospital

Appendix D – Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20

The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

The regulation applies to registered persons when they are carrying on a regulated activity.

CQC can prosecute for a breach of parts 20(2)(a) and 20(3) of this regulation and can move directly to prosecution without first serving a Warning Notice. Additionally, CQC may also take other regulatory action. See the offences section of this guidance for more detail.

The regulation in full

20.—

1. Registered persons must act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity.
2. As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a registered person must—
    a. notify the relevant person that the incident has occurred in accordance with paragraph (3), and
    b. provide reasonable support to the relevant person in relation to the incident, including when giving such notification.
3. The notification to be given under paragraph (2)(a) must—
    a. be given in person by one or more representatives of the registered person,
    b. provide an account, which to the best of the registered person's knowledge is true, of all the facts the registered person knows about the incident as at the date of the notification,
    c. advise the relevant person what further enquiries into the incident the registered person believes are appropriate,
    d. include an apology, and
    e. be recorded in a written record which is kept securely by the registered person.
4. The notification given under paragraph (2)(a) must be followed by a written notification given or sent to the relevant person containing—
    a. the information provided under paragraph (3)(b),
    b. details of any enquiries to be undertaken in accordance with paragraph (3)(c),
    c. the results of any further enquiries into the incident, and

d. an apology.

5. But if the relevant person cannot be contacted in person or declines to speak to the representative of the registered person —
   a. paragraphs (2) to (4) are not to apply, and
   b. a written record is to be kept of attempts to contact or to speak to the relevant person.
6. The registered provider must keep a copy of all correspondence with the relevant person under paragraph (4).
7. In this regulation—
   "apology" means an expression of sorrow or regret in respect of a notifiable safety incident; "moderate harm" means—
   a. harm that requires a moderate increase in treatment, and
   b. significant, but not permanent, harm;

   "moderate increase in treatment" means an unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another treatment area (such as intensive care);
   "notifiable safety incident" has the meaning given in paragraphs (8) and (9);
   "prolonged pain" means pain which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days;
   "prolonged psychological harm" means psychological harm which a service user has experienced, or is likely to experience, for a continuous period of at least 28 days;
   "relevant person" means the service user or, in the following circumstances, a person lawfully acting on their behalf—
   c. on the death of the service user,
   d. where the service user is under 16 and not competent to make a decision in relation to their care or treatment, or
   e. where the service user is 16 or over and lacks capacity in relation to the matter;

   "severe harm" means a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb or organ or brain damage, that is related directly to the incident and not related to the natural course of the service user's illness or underlying condition.
8. In relation to a health service body, "notifiable safety incident" means any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional, could result in, or appears to have resulted in—
   a. the death of the service user, where the death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition, or
   b. severe harm, moderate harm or prolonged psychological harm to the service user.
9. In relation to any other registered person, "notifiable safety incident" means any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional—

a. appears to have resulted in—
    i. the death of the service user, where the death relates directly to the incident rather than to the natural course of the service user's illness or underlying condition,
    ii. an impairment of the sensory, motor or intellectual functions of the service user which has lasted, or is likely to last, for a continuous period of at least 28 days,
    iii. changes to the structure of the service user's body,
    iv. the service user experiencing prolonged pain or prolonged psychological harm, or
    v. the shortening of the life expectancy of the service user; or
b. requires treatment by a health care professional in order to prevent—
    i. the death of the service user, or
    ii. any injury to the service user which, if left untreated, would lead to one or more of the outcomes mentioned in sub-paragraph (a).

Appendix E – Terms of reference for the internal investigation

Independent investigation into the care and treatment of RM and PT by Dorset Healthcare University NHS Foundation T[redacted]st [redacted]

Purpose

To identify the root causes and key learning following the incident involving RM and PT. The investigation process should also identify areas where improvements to ser[redacted]s mi[redacted]be required, which could help prevent similar incidents from occurring.

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

Objectives

- To establish the facts i.e. **what** happened (effect), to **whom, when, where, how** and **why** (root causes).
- To establish whether failings or omissions occurred in care or treatment and to look for improvements rather than to apportion blame
- To establish how recurrence may be reduced or eliminated
- To formulate recommendations, an action plan and to provide a report and record of the investigation process and outcomes
- To provide a means of sharing learning from the incident and to identify routes for sharing learning from the incident.

Key Deliverables and Output

- A final report that can be published, that is easy to read and follow and details information about the incident and the care that both the service users received.
- Identify any care and service delivery problems that may be contributory factors or root causes to the incident or other areas for learning.
- Identify aspects of notable practice and make recommendations for improving future practice or care from both the notable practice and areas of concern.
- Identify and consider any salient housing issues that were documented in PT's clinical records or documentation/correspondence produced or received by PT's S[redacted]l Worker that should be shared with the relevant Local Authority as part of an[redacted]t health and social care learning.
- Establish appropriate contacts and communications with both families to ensure appropriate engagement with the investigation process

- Share the findings of the investigation with the clinical team and the families to include information about the issues and potential learning that will be taken forward within the Trust

- The team owning the action plan i.e. CMHT AMHT - Poole Central will be responsible for the implementation of any actions at a direct service level and the Head of Mental Health will be responsible for overseeing the recommendations of any wider Adult Community Mental Health Services actions required.

Scope of the Investigation

The investigation should be undertaken within the agreed timescales as set out below:

The final draft report to be made available by **14th October 2016** for consideration by the Serious Incidents Requiring Investigation Panel on 21st October 2016.

The final approved report to be shared with Commissioners and closed on STEIS by 8th November in line with the 60 day timeframe as set out in the National Framework. Any deviation from this should be negotiated with the Commissioning Manager.

The scope of the investigation will include an overview of [redacted] and [redacted] involvement with mental health services provided by the Trust concluding with the incidents that resulted in the death of [redacted]

To establish the clinical risk management and clinical care of [redacted] and [redacted], comparing this to the 'best practice' reflected within national and local guidance/ pathways.

To establish if the risk assessment and risk management of the patient was sufficient in relation to their needs and the risks presented in the management of their conditions.

Whether the assessment, planning and implementation of care delivered to [redacted] and [redacted] was of the standard expected by the organisation as per which Dorset HealthCare NHS Foundation Trust policies.

Whether the assessment, planning and implementation of care delivered to [redacted] and [redacted] was of the standard expected by relevant professional bodies NMC and GMC.

To interview family/ staff / clinicians involved in the patient's care to ascertain their views on the patient's risks and the risk management plan.

At the inception of RIO for patient records – how are previous patient records/history accessed and taken into consideration.

Investigation Type, process and methods to be used

External investigation of the unexpected death of a male community patient. Another male community patient was arrested on suspicion of his attempted murder.

Arrangements for communication, monitoring, evaluation and action

Commissioning Manager

[redacted] Head of Mental Health, [redacted]

Clinical Lead

[redacted] Consultant Clinical and Forensic Psychologist [redacted]

SIRI Manager

[redacted] Head of Patient Safety and Risk, [redacted]

Investigation Officer / Team

Consideration should be given to involvement of specialists to support the investigation and if this required the Clinical Lead [redacted] should be contacted in the first instance

Resources

Administrative support if required will be provided by Dorset HealthCare. This can be accessed via [redacted]

RiO Access

In relation to RiO access, the Trust will not issue a RiO card to non-Trust employees. Therefore, when they undertake the review of the RiO records, a member of Trust staff will need to log on RiO for them, this can be agreed with [redacted] when the review of notes are required. Upon accessing the RIO record there should be a clear reference "RiO Records accessed for the purposes of investigation into incident"

Information Governance and Data Protection

Investigators will have access to confidential patient information during the course of their investigation, as NHS employees, they will be expected to abide by the following document: "Confidentiality: NHS Code of Practice" and additionally, if staff are clinical staff any relevant professional codes i.e. NMC/GMC

Terms of reference agreed by Clinical Lead [redacted] Dorset HealthCare University NHS Foundation Trust

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Date:

Terms of reference agreed by Investigating Officer [redacted]

Date:

Appendix F – Contributory factors classification framework

Patient factors	Components
Clinical condition	Pre-existing co-morbidity Complexity of condition Seriousness of condition
Social Factors	Lifestyle (smoking/ drinking/ drugs/diet) Sub-standard living accommodation (e.g. dilapidated) Life events Lack of support networks / (social protective factors -Mental Health Services) Engaging in high risk activity
Mental/psychological Factors	Motivation issue Stress / Trauma Existing mental health disorder Lack of intent (Mental Health Services)
Interpersonal relationships	Staff to patient and patient to staff Patient engagement with services Patient to patient
Staff factors	**Components**
Cognitive factors	Preoccupation / narrowed focus (Situational awareness problems) Perception/viewpoint affected by info. or mindset (Expectation/Confirmation bias) Inadequate decision/action caused by Group influence
Task factors	**Components**
Guidelines, policies and procedures	Not adhered to / not followed Not monitored / reviewed
Decision making aids	Aids not available (e.g. CTG machine; checklist; risk assessment tool; fax machine to enable remote assessment of results) Aids not working (e.g. CTG machine, risk assessment tool, fax machine) Incomplete information (test results, patient history)
Procedural or task design	Misrepresentation of information Inappropriate transfer of processes from other situations Inadequate Audit, Quality control, Quality Assurance built into the task design

Communication	Components
Written communication	Records incomplete or not contemporaneous (e.g. unavailability of patient management plans, patient risk assessments, etc) Written information not circulated to all team members Communication not received Lack of effective communication to staff of risks (Alerts systems etc)
Communication management	Lack of effective communication to patients about incidents (being open) Information from patient/carer disregarded Ineffective communication flow to staff up, down and across Ineffective interface for communicating with other agencies (partnership working) Lack of measures for monitoring communication
Work environment	**Components**
Staffing	Inappropriate skill mix (e.g. Lack of senior staff; Trained staff; Approp. trained staff)
Organisational	**Components**
Organisational structure	Hierarchical structure/Governance structure not conducive to discussion, problem sharing, etc.
Safety culture	Lack of risk management plans
Education and training	**Components**
Competence	Inexperience Inappropriate experience or lack of quality experience
Team factors	**Components**
Role congruence	Lack of shared understanding