An independent mental health homicide investigation into the care and treatment of Ian following the murder of Mr Kamil Ahmad Allamurad.

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Sancus Solutions' investigation team would like to acknowledge the contribution and support of staff from Avon and Wiltshire Mental Health Partnership NHS Trust, Cygnet Health Care, Milestones Trust, United Communities, South Gloucestershire and North Somerset Clinical Commissioning Groups and the Prior Surgery.

Sancus Solutions wish to thank Kamil's for their contribution to this investigation and it is hoped that this report does not contribute further to their pain and distress.

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Appendixes

Executive summary

Incident

On 6 July 2016 at 4pm, Ian was discharged from a Cygnet Health Care's inpatient unit[1]. In the early hours of 7 July 2016, Ian telephoned the police to report that he had killed Kamil.[2] At the subsequent trial, Ian was found guilty of the murder of Kamil and given a life sentence. He is currently detained in a high-security hospital.

Sancus Solutions' investigation

NHS England (South) commissioned Sancus Solutions[3] to undertake a mental health homicide investigation.[4] The primary focus of this investigation was to:

- Critically analyse the care and treatment provided to Ian by the involved primary, secondary and third sector health and social care agencies, with particular regard to the events that led up to Ian's hospital admission on 13 June 2016.

- Consider if the incident was predictable,[5] preventable[6] or avoidable.[7]

Kamil's family[8] also asked Sancus Solutions to review:

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[1] The Cygnet Health Care's PICU unit involved in this incident is located outside of the Bristol locality. The hospital is a 70-bedded low-secure psychiatric hospital, consisting of five wards. The hospital is registered to provide treatment of disease, disorder and injury, and assessment or medical treatment of people detained under the Mental Health Act 1983. A management agreement was in place between Cygnet Health Care and AWP to provide additional beds for AWP patients. As a response to this incident, this agreement has been reviewed. Cygnet Health Care PICU

[2] Kamil's family requested that Kamil's name be used in this report.

[3] Sancus Solutions provide a range of professional investigation services, including Domestic Homicide Reviews and NHS England Homicide and Serious Incident Investigations, as well as investigative training to public, private and third sector organisations. Sancus Solutions

[4] NHS England Serious Incident Framework – independent mental health homicide investigations are undertaken "When a homicide has been committed by a person who is, or has been, in receipt of care and has been subject to the regular or enhanced care programme approach or is under the care of specialist mental health services, in the 6 months prior to the event."

[5] Predictability - the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it. 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. Predictability is "the quality of being regarded as likely to happen, as behaviour or an event". We will identify if there were any missed opportunities which, if actioned, may have resulted in a different outcome. 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.

[6] Preventability – to prevent means to "stop or hinder something from happening, especially by advance planning or action" and implies "anticipatory counteraction"; therefore, for a homicide to have been preventable there would have to have been the knowledge, legal means and opportunity to stop the incident from occurring

[7] The National Learning Disability Mortality Review Programme is working with other agencies, such as the Learning Disability Public Health Observatory and the Transforming Care (Winterbourne View) Improvement Programme, to reduce health inequalities faced by people with learning disabilities. Learning Disability Mortality Review Programme

[8] Ian's family were invited to contribute to this investigation but declined

"The quality of all clinical risk assessment to determine if Ian posed specific risks to the victim based on their ethnicity, gender, race, religion or culture. If risks of this nature were identified, were they formulated as potential Hate Crimes and were appropriate steps to mitigate/address those risks taken."[9].

Other investigations

Following this incident both AWP and Cygnet Health Care undertook a post incident investigation (hereafter referred to as SI). NHS England has asked that Sancus Solutions:

"Review AWP's and Cygnet Health Care's post-incident serious incident investigation reports, their Duty of Candour[10] and the progress they have made on implementing their action plans."[11].

Additionally, SAB commissioned an independent review (hereafter referred to as SAR).[12] The SAR[13] focused on the involved service provision with regard to both Ian and Kamil.

Sancus Solutions' intention was not to duplicate these post-incident investigations but to identify and provide further commentary and analysis on the care and treatment of Ian.

The following sections provides a very brief summary of Sancus Solutions' findings and recommendations with regard to NHS England's terms of reference[14] and other key lines of inquiry that were identified in the course of their investigation.

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[9] NHS England Terms of Reference (ToR) p1

[10] Duty of candour is a legal requirement for health, care service and social work organisations to inform people (and their families) when they have been harmed (either physically or psychologically) as a result of the care or treatment they have received. 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 providing an apology when things go wrong. Duty of Candour

[11] NHS England ToR

[12] The Care Act 2014 states that Safeguarding Adults Boards must arrange a Safeguarding Adults Review (SAR) when an adult with care and support needs dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. Safeguarding Adult Boards must also arrange an SAR if an adult in its area has not died, but the Board knows or suspects that the adult has experienced serious abuse or neglect.

[13] Report published June 2016. SAR

[14] See appendix A

Ian's mental health

At the age of 26 years, Ian was given a mental health diagnosis of paranoid schizophrenia – ICD code F20.[15] Ian also had an extensive forensic history, which included two serious assaults (1987 and 1988) on members of the nursing staff where he was being detained under a Section 37 of the Mental Health Act 1983[16], with a Restriction Order under Section 41 Without Limit of Time.[17]

In November 2015, following a number of amber and red blood test alerts, Ian's atypical antipsychotic medication, clozapine,[18] was stopped. From this point, there was increasing concern with regard to Ian's mental health and his antisocial behaviour within the supported housing scheme where he was a tenant. Avon and Wiltshire Mental Health Partnership NHS Trust's (hereafter referred to as AWP) assessment and recovery team increased their support, and at times Bristol Crisis Service (hereafter referred to as BCS) provided additional, out-of-hours support. There were also a number of disclosures made by Ian that his substance and alcohol misuse was significantly increasing.

Historically, Ian's mental health was at its most stable and his risk of harm to others was assessed as being low, when he was being prescribed clozapine. However, repeatedly this medication regime had to be stopped following amber or red alert[19] blood tests. This occurred for the last time in November 2015. From this point, there was increasing evidence that Ian's mental health was deteriorating, and he was being supported by South Bristol Assessment and Recovery Service[20] and on occasions BCS.[21]

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[15] Statistical Classification of Diseases and Related Health Problems (ICD). ICD

[16] Where the Crown Court has made a Section 37 Hospital Order, it may also impose restrictions on a patient's discharge. Before they make such an order, they must be satisfied that it is necessary to do so to protect the public from serious harm. It means that a patient cannot be discharged from hospital unless the Ministry of Justice or a Tribunal grants permission that a patient can be discharged. The discharge may be subject to certain conditions

[17] Section 41 is also called a "restriction order". An appeal to the Mental Health Tribunal can be made once in the first 12 to 24 months after the conditional discharge and then once in every two-year period after that. Section 41

[18] Clozapine is an atypical antipsychotic that is used for treatment-resistant schizophrenia. The drug is subject to strict monitoring requirements because it is associated with serious side effects, such as neutropenia, agranulocytosis, leukopenia (lowered white blood cell count), myocarditis (inflammation of the heart muscle) and cardiomyopathy. Patients newly started on clozapine must have a full blood count (FBC) taken weekly for the first 18 weeks of treatment and then fortnightly for the next 34 weeks. After that, they receive monthly monitoring for as long as they are taking clozapine**.** Amber result**:** clozapine can be dispensed, but FBC must be monitored twice a week. Red result**:** stop clozapine and monitor FBC daily until results return to normal. NICE guidelines

[19] Red result**:** stop clozapine and monitor FBC daily until results return to normal-green. NICE guidelines

[20] South Bristol Recovery Service (Recovery Service), provided by AWP, is a community mental health team that provides secondary-level mental health assessment, support, treatment and care coordination under the Care Programme Approach (CPA) Recovery Service

[21] The Bristol Crisis Service (BCS), provided by AWP, operates a 24-hour service, 7 days a week, 365 days a year. Service users requiring "emergency" (within 4 hour) assessments will be transferred to the BCS by their

Housing and community support

Kamil and Ian were both tenants at a supported housing scheme managed by Milestones Trust.[22] There were a significant number of incidents where Ian was verbally and racially abusive towards Ian. Ian had also physically assaulted Kamil and on occasions other tenants. There were also several incidents where Ian was sexuality inappropriate towards female tenants.

Ian was issued with a number of verbal and written warnings, and in January 2014 Milestones Trust commenced unsuccessful legal proceedings to evict him. Following some of the incidents, Milestones Trust's staff submitted safeguarding alerts to Bristol Safeguarding Adults Board (hereafter referred to as SAB)[23] in which Kamil was identified as one of the victims.

Last inpatient admission – 13 June 2016 to 6 July 2016

Between 10 and 12 June 2016, Ian had posted over 30 handwritten notes under the staff office door that contained delusional and abusive comments and also threats to kill named tenants, including Kamil, and members of the public. Ian was also recorded on CCTV in the communal areas being sexually inappropriate. Police arrested him on suspicion of making threats to kill and indecent exposure (13 June 2016) and he was subsequently assessed and detained under a section 2[24] of the Mental Health Act 1983.

Ian was initially placed in an AWP Psychiatric Intensive Care Unit (hereafter referred to as PICU)[25], and then, due to bed management issues at the time he was transferred to a local Cygnet Health Care hospital. He was initially placed on their PICU unit and was subsequently transferred to an open ward.

A First-tier Mental Health Tribunal was held on 28 June 2016. The tribunal concluded that based on evidence presented, Ian did not meet the criteria for further detention.

GP; they can self -refer or be referred by family/friends, the Liaison/Court Diversion Service, the mental health liaison service, police and ambulance staff, and others. In a crisis, the BCS endeavour to engage and support anyone needing immediate and intensive input.

[22] Milestones Trust is a charity that supports people with learning disabilities, mental health needs and dementia in Bristol. Milestones Trust

[23] The Safeguarding Adults Board (SAB) is a statutory partnership of all the organisations working to safeguard adults at risk. Followng an alert, SAB's role, supported by Adult Care Team Managers, is to investigate/enable all agencies to achieve consistent and robust arrangements for safeguarding people with care and support needs, to implement effective safeguarding plans which minimise risk of harm, to adopt a zero tolerance approach to abuse and neglect, and to stop abuse. Bristol SAB

[24] The criteria for Section 2 are that the person is potentially suffering from a mental disorder of a nature or degree which warrants their detention in hospital and that it is in the interests of the person's own health, their safety or that of others. A patient can be detained for up to 28 days for assessment purposes and has the right to appeal. The appeal must be submitted within the first 14 days.

[25] AWP's PICU inpatient unit is a 12-bedded unit for patients who are mostly presenting with acute psychotic and behavioural dysregulation that is unmanageable on other units or in the community. The majority of care offered is intensive and seeks to stabilise patients with medication, support and therapy, with a view to helping them step down onto a less supported open ward, as their care needs become less intense. AWP PICU

However, in response to the reports submitted by the inpatient consultant psychiatrist and the AWP Care Coordinator, regarding the suitability of Ian's accommodation and Milestones Trust's intention to serve him with a Notice to Quit[26], the tribunal panel agreed to a delay in the date of Ian's section being discharged to allow time for a discharge planning meeting to be convened.

No such planning took place until the day of Ian's discharge, when, on being informed that Ian was going to be discharged, Milestones Trust instructed their housing managing agent, United Communities Housing Association (UCHA)[27], to commence eviction proceedings. However, due to the time that UCHA were notified, they were unable to instigate proceedings until the following day, so Ian was able to return to the scheme.

Findings

Recovery Navigator[28] and Bristol Mental Health[29]

From March 2015 the recovery navigator, based within South Bristol Recovery Service, began supporting Ian. The recovery navigator's role was to provide ongoing support, coordinate Ian's blood tests and to deliver his clozapine medication.

By July 2015 the care coordinator had reduced his involvement to monthly visits to dispense Ian's depot injection. There was considerable evidence that when Ian became unwell (from November 2015 to June 2016), the recovery navigator was regularly liaising with the staff from Milestones Trust and was visiting Ian with the Assessment and Recovery Service's community consultant psychiatrist and members of the BCS team.

Sancus Solutions' investigation team (hereafter referred to as the investigation team) concluded that when Ian's clozapine had to be stopped (November 2015), given his known mental health and forensic history, in addition to his escalating risk factors, a senior practitioner within the assessment and recovery team should have assumed the role of care coordination, including having responsibility for reviewing his risk assessments and care plans.

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[26] A notice to quit is the notice that has to be served by a landlord, requesting that the tenant leaves their accommodation by a certain date (usually 30 days). If a tenant does not leave the property by the end of this notice period, the landlord must take action in court to have them evicted.

[27] United Communities were the housing management agency that provided advice and management of tenancies for Milestones Trust. United Communities

[28] Ian's recovery navigator was recruited by a third sector women's mental health and housing agency on the grade that is equivalent to an NHS band 4

[29] In October 2014 a partnership, involving AWP and a number of third sector agencies, successfully tendered to provide mental health services within the city of Bristol. This service is now known as Bristol Mental Health. There are 18 partner agencies, which provide a variety of community mental health, housing, crisis, support and advocacy services. AWP provides the adult mental health inpatient services. Bristol Mental Health

The investigation team also concluded that risk training that is currently provided to recovery navigators is not adequate and should be addressed as a matter of urgency to ensure that both a comprehensive induction and an ongoing risk training programme are provided (recommendation 1).

The investigation team also noted that AWP's CPA and Risk policy did not provide clarity with regard to the roles and responsibilities of recovery navigators and care coordinators, especially in situations in which a patient's risks are escalating (recommendation 3).

It was noticeable to the investigation team that neither AWP's SIR, nor the SAR identified or considered the role and responsibilities of the recovery navigator. The recovery navigator reported that she had not been invited to contribute to either investigation or the learning events that took place. This, the investigation team would suggest, was a significant oversight, as not only did she have a significant role in the support and assessments of Ian, but the learning from both investigations would have contributed to her professional development.

AWP's risk assessments and risk management

During the course of Sancus Solutions' investigation, it was noted that there was evidence that the involved AWP and Milestones Trust practitioners were, in the main, responsive in providing increasing levels of support to Ian, at times when his mental health was deteriorating and his risks were perceived to be escalating. However, the investigation team agreed with AWP's SI report's finding that given Ian's medical history and high-risk profile, "his care plans and risk assessments were not as comprehensive as expected"[30].

There was no evidence that Ian's care coordinator was supervising the content of the assessments that were being undertaken by the recovery navigator or ensuring that the assessments and care plans were being reviewed as per policy and in response to Ian's escalating risks. This was particularly concerning to the investigation team, when it was clearly evident that from November 2015 there was a significant increase in Ian's risks, especially with regard to his risk of harm to others, and it was also known that his alcohol and substance misuse was increasing.

Neither Milestones Trust nor Ian's GP were asked to contribute to risk assessments undertaken by the inpatient units of AWP and Cygnet Health Care. The investigation team have concluded that this was a significant error, as both agencies could have provided valuable information about Ian, the risks that he was posing to other tenants and the suitability of the placement.

[30] AWP's SI report p3

Milestones Trust did not receive a copy of AWP's risk assessments. Again, this would have been extremely helpful, not only in the management of Ian and his risks to other tenants, but also to inform their housing management decisions.

The investigation team have concluded that:

- From November 2015, such was the level of Ian's risk indicators, in combination with an increasing absence of protective factors, that a senior and clinically qualified member of the assessment and recovery team should have assumed an overall care coordination role and should have been reviewing Ian's risk assessments on an ongoing basis.
- Given the known risks, both historic and current, the investigation team would have expected that Ian's risks were assessed as high at times when his clozapine had to be stooped and when his mental health was deteriorating.
- The risk assessments and risk management plans undertaken by members of AWP's assessment and recovery team were not adequate and were non-compliant with AWP's CPA and Risk Policy and best practice guidelines.
- A multiagency risk assessment and management plan should have been undertaken where information could have been shared between agencies and a crisis management plan agreed.

The investigation team have recommended that where a care coordinator and a recovery navigator are holding joint responsibility for a patient, there should be regular joint supervision sessions to ensure that the appropriate level of risk assessment and care planning is being provided (recommendation 4).

The investigation team have also recommended that AWP updates its Risk Summaries-point in time pro forma to ensure that a more robust and systemic risk assessment is developed across services working in partnership with AWP (recommendation 5).

Cygnet Health Care's risk management and care planning

A number of comprehensive mental health, risk and support assessments were undertaken by Cygnet Health Care's inpatient unit. However, the focus of these assessments was the inpatient admission, and until the day of Ian's discharge, there was no assessment or consideration by the inpatient staff of his support needs or risk(s) after discharge.

Cygnet Health Care's inpatient unit also made no contact with Milestones Trust, Ian's GP or AWP's assessment and recovery team to obtain information to inform their risk assessments or their report to the Mental Health Tribunal.

One of the findings of Cygnet Health Care's SI report was that "little information was received about [Ian's] previous history or his behaviour since [his] admission to Hazel Ward"[31]. The investigation team did not agree with this finding, as they concluded that a reasonable amount of information was forwarded as part of AWP's inpatient unit's referral. Which included:

The Risk Summary that was completed on Ian's admission. This summary assessed that Ian's risks of harm to others was high, it identified that there were risks to vulnerable adults, and a risk of violence/aggression and abuse to family, the general public, other clients and staff. This section also documented details of Ian's forensic history, including two serious assaults, in 1987 and 1991, when he assaulted members of an inpatient unit's nursing staff; and six incidents of violent and disinhibited and sexualised behaviours, from 2013 to 2016, involving tenants from the supported housing scheme. It specifically identified Kamil as one of the victims. It was noted that Kamil was of "Kurdish origin… query racially driven attack." [277].

Additionally, the investigation team were of the opinion that, if further information was required, members of Cygnet Health Care's inpatient unit should have made direct contact with Milestones Trust, Ian's GP and AWP's assessment and recovery team in order to obtain information about Ian and the situation prior to his Mental Health Act 1983 assessment. The investigation team concluded that this was a significant missed opportunity.

In addition, AWP's assessment and recovery team and Milestones Trust failed to take any proactive steps to make contact with the other agencies in order to share information and to discuss a discharge plan, which would provide support to Ian and minimise any potential risks to him and the other tenants.

The investigation team have recommended that as Cygnet Health Care are still commissioned to accept a number of AWP's patients' consideration should be given to allowing them to have electronic access to the patient's AWP patient records (recommendation 7).

Milestones Trust's risk management

Milestones Trust's management report[32], which was completed for the SAR, concluded that:

[31] Cygnet Health Care SI report p20. One of the recommendations of the SI report was "that the Cygnet team arrange a meeting with AWP to discuss how going forward all information can be made available and post admission where the team should be targeting their requests"

[32] Completed by Milestone Trust's director of operations,

> "The written documentation in the files for the tenants was limited. In particular there was a lack of a formal risk assessment process. Where risk had been identified there was no risk management plans in place. Despite this, the evidence was that appropriate actions were taken to address risk."[33]

The investigation team agreed that the risk assessment and risk management planning process that were completed were inadequate.

Since this incident, Milestones Trust has introduced a more robust risk assessment process. The investigation team reviewed this process and were of the opinion that, due to the number of risk assessments that needed to be completed, the process was placing an administrative burden on managers and support staff.

The investigation team obtained evidence confirming that prior to Ian's inpatient admission, members of the supported housing scheme support staff and the management team were initiating regular contact with Ian's care coordinator, recovery navigator and members of the BCC. They were also assessing and reporting potential risks posed by Ian to other tenants, including Kamil, via the safeguarding reports.

It was also reported to the investigation team that since this incident there had been meetings between AWP and Milestones Trust to discuss both the incident and to develop a protocol for improving information sharing. However, Milestones Trust staff reported that that they do not routinely share their risk assessments with other agencies and also they do not receive copies of AWP's risk assessments (recommendation 6).

The investigation team have recommended that Milestones Trust undertake a further review of their current risk assessment process to develop a more recognised assessment tool that is more closely aligned with AWP's risk assessment (recommendation 8).

Additionally, the investigation team have highlighted a number of deficits in Milestones Trust's lone working assessment process. During the course of this investigation Milestone Trust reported that since this incident they have reviewed their lone working risk assessment.

Forensic assessment

30 December 2013: After Ian's Section 2 of the Mental Health Act 1983 was rescinded and he was discharged into the community, a discharge summary was

[33] SAR agency report Milestones Trust p24

sent to his GP. This letter commented that Ian was "dangerous when he [was] unwell"[34] and that a community forensic opinion was to be obtained in order to review Ian's accommodation and long-term treatment plan. There is no evidence that this occurred.

February 2016: AWP's SI report documented that the opinion of a forensic consultant psychiatrist was sought by the assessment and recovery service. This occurred at a liaison meeting, which was convened to discuss Ian's presenting risk factors and his future risk management. However, this meeting was not documented.

AWP's SI report identified the lack of documentation and concluded that "the forensic opinion did not go on to inform the care, treatment and risk management of [Ian]." [35] One of the SI report's recommendations addressed this particular deficit.

The investigation team concluded that there were a number of options that were available to AWP's assessment and recovery team that were not actioned – for example, requesting that a Historical Clinical Risk Management-20 (HCR-20) assessment[36] be undertaken by a member of AWP's forensic team, or reporting Ian to the police as a Potentially Dangerous Person (PDP).[37]

Sancus Solutions' investigation team have recommended that members of AWP's assessment and recovery team should be provided with a professional development session on the role and function of the police's PDP scheme (recommendation 9).

Involvement of Ian's family in risk assessment and care planning

The investigation team could find no evidence that any of the involved agencies involved Ian's family in the risk assessments and care plans.

The investigation team have concluded that AWP's assessment and recovery team and its inpatient unit, Cygnet Health Care's inpatient unit, and Milestones Trust's supported housing scheme must review their practice with reference to the following six key elements that are outlined in the Triangle of Care[38] (recommendation 10).

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[34] Discharge summary January 2014 p2
[35] AWP SI report p52
[36] HCR 20 is an *assessment* tool that helps mental health professionals estimate a person's probability of violence. HCR-20
[37] A PDP is a person who is not currently managed in one of the three multi-agency public protection arrangements (MAPPA) categories, but w hose behaviour gives reasonable grounds for believing that there is a present likelihood of them committing an offence or offences that will cause serious harm. PDP
[38] The Triangle of Care offers key principles and resources to influence services and other people working with carers to be more effective in involving them within acute care. Triangle of Care is a therapeutic alliance between

Discharge planning

The investigation team concluded that the evidence indicated that Ian's discharge was poorly managed. The evidence indicates that there was a combination of reasons why this occurred:

- AWP's bed manager, who usually attended ward rounds at Cygnet Health Care's inpatient unit, was on holiday, and there were, at the time, no arrangements in place to provide cover. The investigation team were provided with evidence that this issue has now been addressed.

- There was no liaison, either prior to the Mental Health Tribunal or prior to Ian's discharge date, between the Cygnet Health Care and AWPs' psychiatric teams to discuss discharge and treatment plans.

- After the Mental Health Tribunal none of the involved community agencies made contact with Cygnet Health Care's inpatient unit until the day of Ian's discharge.

- As Milestones Trust did not make contact with Ian's care coordinator, they were unaware of the date that Ian was to be discharged; therefore, they were not able to instruct UCHA to action emergency eviction procedures as Ian had the legal right to return to his accommodation.

First-tier Mental Health Tribunal

Both Cygnet Health Care's inpatient consultant psychiatrist and AWP's care coordinator presented reports to the First Tier Mental Health Tribunal (hereafter referred to as Mental Health Tribunal).

Social Circumstances report- Given the time scale that the care coordinator had to produce his Social Circumstances report the investigation team concluded that it was fairly comprehensive. As part of the report the care coordinator documented information obtained from Milestone Trust about Ian's tenancy status.

Cygnet Health Care's consultant psychiatrist's report- the investigation team concluded that the report was based on information that was provided by the inpatient unit which included a risk assessment, details of Ian's historic and recent forensic history as well as the assessments that had been undertaken since Ian's transfer to Cygnet Health Care. The report clearly documented the nature and degree of Ian's disorder and the challenges that the inpatient unit faced in their treatment of him.

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service user, staff member and carer that promotes safety, supports recovery and sustains well-being. Triangle of Care

There was no evidence that the consultant psychiatrist contacted AWP inpatient or community mental health services or Milestone Trust in order to obtain further information regarding their assessments or involvement with Ian. The investigation team concluded that this was a significant error as all these agencies would have been able to have provided significant information that could have informed the report to the Mental Health Tribunal panel.

It was documented that the consultant psychiatrist reported to the Mental Health Tribunal that in his opinion it was in Ian's best interest to be transferred back to AWP's inpatient unit prior to discharge.

The Mental Health Tribunal panel concluded that the argument presented by the consultant psychiatrist "relied upon the nature of the disorder rather than the degree[39] … [the] chronicity of the illness, its historic high risk profile and in particular the very risky behaviour at the patient's accommodation prior to the admission."[40] The Mental Health Tribunal panel concluded that although they were satisfied that Ian had a mental disorder he was currently presenting as asymptomatic therefore, they could not see the benefits in any further inpatient assessments or treatments that could not be undertaken in the community. However, the care coordinator and the consultant psychiatrist had been persuasive in their argument that a robust discharge care plan needed to be agreed with all involved community agencies prior to Ian's discharge. Therefore, the Mental Health Tribunal panel concluded that as it was unlikely that Ian would remain in hospital on an informal basis the decision was made to defer Ian's section discharge "for a period to allow for further discharge planning"[41].

The investigation team concluded that based on the evidence that was available to the Mental Health Tribunal panel their decision to discharge Ian's Section 2 of the Mental Health Act 1983, with a deferred date, was proportionate to Ian's presentation and it also took into account his accommodation situation. However:

- Milestones Trust were not informed of the Mental Health Tribunal panel's decision to discharge Ian's section until the day of discharge therefore, the housing management action that was available to them, to prevent Ian from returning to the scheme, was very limited.

[39] Nature and/or degree: the test requires that appropriate treatment is actually available for the patient. It is not enough that appropriate treatment exists in theory for the patient's condition. Case law has established that "nature" refers to the particular mental disorder from which the patient is suffering, its chronicity, its prognosis, and the patient's previous response to receiving treatment for the disorder. "Degree" refers to the current manifestation of the patient's disorder. Nature and degree

[40] First-tier Tribunal report 28 June 2016 p4

[41] First-tier Tribunal report 28 June 2016 p5

- There was no discharge risk assessment or care planning undertaken by any of the involved services until the day of Ian's discharge.
- On being informed that Ian was to be discharged that day Milestone Trust advised the tenants on what action they needed to take if they were concerned about their safety. However, they were unable to locate Kamil who was out of the service.

Police

Prior to Ian's detention under the Mental Health Act 1983 he had been arrested on suspicion of making threats to kill and indecent exposure (13 June 2016) due to his admission to the inpatient unit the charges were pending further investigation. There was some communication with the police and AWP inpatient unit staff but once he was transferred to Cygnet Health Care inpatient unit and subsequently discharged there was no further updates provided or requested by the police. Therefore, they were unaware that he had been discharged.

Housing management

Ian

Ian moved into Milestone Trust supported housing scheme in June 2010 and until Kamil moved into the property (January 2013) there were no reported incidents involving Ian. It was documented that Ian maintained his accommodation well and for the most part engaged with the housing support being offered.

From 2013 to 2016, there were a number of significant incidents involving Ian and other tenants, including Kamil, in which he was the instigator of verbal and physical aggression, racial abuse, antisocial and sexually disinhibited behaviours. There were also incidents where Ian was exhibiting verbal aggression and intimidating behaviours towards members of the supported housing scheme's staff.

It was clearly evident that during periods when Ian's mental health was deteriorating, there was a significant escalation in his antisocial behaviours. Milestones Trust's staff were also reporting to AWP's practitioners that when Ian was mentally unwell, he became fixated on Kamil's asylum seeker status. For example, he was attempting to intercept Kamil's post and was questioning staff about Kamil's right to remain in the UK. Additionally, there were observations being reported that some of the ongoing conflict between Ian and Kamil was due to their complex relationships with one of the female tenants.

There were also several incidents where it was documented that Kamil was viewed as the instigator of the some of the conflicts with Ian – for example, he cut the TV

cable in the communal area, on another occasion he disclosed to support staff that he was carrying a Stanley knife, which he reported was for his own protection.

Between 5 October 2013 and 8 January 2014, Milestones Trust issued Ian with three written warnings, stating that his behaviours towards both Kamil and some of the other tenants were placing his tenancy at risk.

From 5 October 2013 there were a number of entries in Ian's AWP patient records reporting that concerns had been reported by Milestones Trust's management team regarding the suitability of Ian's placement due to his ongoing antisocial behaviours.

The investigation team concluded that from 2014 there were several occasions when Ian's behaviours were such that Milestones Trust could have sought to either action eviction proceedings or convene a multi-disciplinary meeting in order to agree a planned move for Ian. However, due to the type of tenancy agreement issued to Ian, eviction procedures would have taken a considerable amount of time to action and unless an injunction was issued by a court, Ian would have had the right to return to his property. Additionally, creating a situation where Ian, who was a vulnerable adult, was homeless would need to have been carefully considered by those who had a duty of care for him.

The investigation team concluded that these were significant missed opportunities where the involved agencies could have proactively resolved the ongoing concerns regarding Ian's risk of harm to other vulnerable tenants.

Kamil

Kamil's family reported to the investigation team that, in their opinion, Ian's racist attitude and actions towards Kamil were not a manifestation of a deterioration in his mental health but rather, he was a person with racist views who was mentally ill. The SAR agreed with this opinion, stating that Ian:

"Held racist opinions, and his attitude towards Kamil was not the result of the deterioration in his mental health, in short, he was a person with racist views who was mentally ill, and rather than a mentally ill person whose racism was a manifestation of their illness. These views crystallised into a personal hatred of Kamil that was based on his race and legal status."[42]

In April 2016, a member of the supported housing staff team contacted AWP's duty team to report that Ian was exhibiting "all of his early warning signs … bizarre and paranoid thinking … he [was] obsessed with everything to do with [Kamil] …

[42] SAR p17

becoming sexually inappropriate with staff and clients … major concerns [regarding Ian's] ongoing fixation with staff and the tenant [Kamil]."[43]

Kamil attended a police station with Milestones Trust staff to report the ongoing harassment from Ian. The police recorded the crime as a hate crime, which gave Kamil the status of an enhanced victim[44], and he was referred to several victim support services. The police made several unsuccessful attempts to contact Kamil, and therefore they were unable to complete their risk assessment. Following this incident Ian was issued with a final written warning.

The investigation team concluded that the incidents where Ian expressed racist opinions and hostility towards both Kamil and other tenants were clearly unacceptable. However, it cannot be ignored that the evidence does indicate that when Ian's behaviours/actions towards Kamil and other female tenants generally escalated during periods when his mental health was deteriorating. It is recognised that individuals who are suffering mental health issues, such as psychosis, mood disorders or cognitive dysfunction, can exhibit antisocial behaviours as a consequence of their cognitive, emotional or relational problems and that they can express distress in verbal and physical hostility, disinhibited behaviour's, difficulty in self-regulating their behaviours and aggression. There is research that suggests that:

"Extreme racist delusions can occur as a major symptom in psychotic disorders, such as schizophrenia and bipolar disorder … as a mental health problem by recognizing it as a delusional psychotic symptom."[45]

Clearly such an explanation is not excusing such behaviours or minimise the profound effects on the victims, and in this case Kamil, who are being targeted. But it does offer some understanding of the causal factors that contributed to Ian's unacceptable behaviours.

The investigation team was informed that the majority of tenants, at the time, in the supported housing scheme and many of the inpatient staff, who had close contact with Ian, were from diverse ethnicities. There was no documented evidence that Ian was racially hostile or behaved in a racially aggressive manner towards them, even when he was unwell. So, this leads to the question, as the authors of the SAR suggest, of what caused the ongoing conflict between Ian and Kamil, and whether:

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[43] AWP progress notes 5 April 2016

[44] The Victims' Code provides for an enhanced service for victims of the most serious crime, persistently targeted victims and vulnerable or intimidated victims. Once a service provider has identified that a victim is eligible for enhanced services, that service provider must ensure that this information is passed on as necessary to other service providers with responsibilities under the Victims' Code and to victims' services where appropriate. Service providers must share information about the victim with each other effectively and in accordance with their obligations under the Data Protection Act. Enhanced victims of crime

[45] Racism

> "Kamil] believed he may need to protect himself because he could not rely on agencies to protect him …. The antipathy[46] between the two men has its origins in their respective vulnerabilities."[47]

Clearly, both individuals had a complex number of social and psychological difficulties, as well as traumatic life experiences, which may have contributed to the complex dynamic between them that sporadically erupted into episodes of verbal and physical conflict.

The question that the investigation team suggest is of equal importance is whether both Ian and Kamil's placements, in a supported housing scheme with minimal staff presence, were suitable for two individuals who had such complex presentations, risks and vulnerabilities. The investigation team have concluded that:

- Both Ian and Kamil required more intensive supported living provision.
- Kamil required a more culturally appropriate environment that could support his needs and risk factors with regard to being a refugee with mental health issues, learning disabilities and post-traumatic stress disorder.

The remit of this investigation is primarily focused on the care and treatment of Ian and not a forensic analysis of the motivation for the crime itself. Sancus Solution's investigation team have concluded that there were a significant number of opportunities where the involved agencies could and should have taken more proactive measures to manage the known risks and support needs of these two vulnerable men.

Alcohol and substance misuse

There was considerable documented evidence that Ian was reporting a significant increase in his alcohol consumption and substance misuse when his clozapine medication had to be stopped. It was also at such times that his antisocial and aggressive behaviours increased, which resulted in incidents involving other tenants, including Kamil.

All of the involved agencies were aware of this issue, yet there was little evidence of a coordinated response. Ian had been a habitual drinker and drug user from a young age, and therefore it is perhaps not surprising that he was resistant to tackling this issue, as he was, at times, using alcohol and illegal substances to manage his mental health symptoms.

[46] Antipathy: a deep-seated feeling of aversion
[47] SAR p16

In addition to the health risks, Ian's alcohol and substance misuse was threatening the security of his tenancy with Milestones Trust. However, neither his care plans nor his risk summaries were highlighting this as a key issue. There also appears to have been no consideration given to the possibility that Ian was presenting with a dual diagnosis.

Physical health

Ian's GP was involved in the regular blood testing with regard to clozapine; however, there was no evidence that Ian was receiving regular annual health checks. Although there was some communication between the GP and the assessment and recovery team with regard to Ian's physical health, it was unclear who was maintaining an overview to ensure that Ian was receiving regular physical health checks.

The investigation team concluded that there was no consistent or coordinated interagency approach to the assessment and support of Ian's physical health risks.

The investigation team have recommended that AWP reviews how its assessment and recovery team undertake and maintains physical health monitoring of patients, who have a complex combination of mental health and physical health issues (recommendation 12).

Predictability

Clearly, there were incidents where Kamil and other tenants were the victims of verbal abuse and threats from Ian. However, there were actually very few occasions when Ian carried out his threats. Indeed, the major concern, both prior to Ian's last admission to hospital and on the day of his discharge, was not only the potential risk to Kamil, but also the safety of the female tenants.

During Ian's last hospital admission there was no evidence that he was experiencing difficulty in self-regulating his response to the other patients or the medical staff.

The investigation team have concluded that, based on the evidence available, there was no indication prior to his discharge that Ian was planning an attack on Kamil. Therefore, the investigation team have agreed with AWP's SI report's finding that, based on Ian's presentation during his last inpatient admission and on the day of his discharge, the fatal attack on Kamil was not predictable.

However, there was clearly a significant and ongoing antipathy between Kamil and Ian that did have the potential to have escalated, into a more serious situation.

Preventability

The investigation team agreed with both the SAR and AWP's SI report's finding that the incident on 7 July 2016 would likely have been prevented if Ian had not returned to Milestones Trust's supported housing scheme. However, this would have required one or more of the following to have occurred:

- If Milestones Trust/UCHA had time to have completed the eviction procedure and/or taken out an injunction to prevent Ian from returning to the scheme.
- If either Kamil or Ian had agreed to move to other accommodation.[48]
- If the police had been informed that Ian was to be discharged from Cygnet Health Care inpatient unit, they may have made the decision to arrest him for the threats he had made prior to his admission therefore he would not have returned to the supported housing scheme.[49]
- Interagency communication and robust discharge planning.
- If the First-tier Tribunal had decided not to discharge Ian's Mental Health Act 1983 section. However, based on evidence presented to the panel, it was assessed that Ian did not meet the criteria for further detention. It would not have been lawful to have detained Ian further on the basis that his accommodation was no longer suitable.

If any of the above had been actioned the risk of Ian having access to Kami would have been significantly reduced, and therefore this incident would likely on that night, have been prevented.

Avoidability

The investigation team has identified the set of circumstances/actions that may have prevented this incident from occurring on 7 July 2016 therefore, it is likely that the death of Kamil on 7 July 2016 could have been avoided.

AWP's serious incident investigation

The investigation team concluded that AWP's investigation process and SI report was, in the main, comprehensive and well written. It not only provided information about AWP's involvement but also critically reviewed and highlighted where there were deficits and concerns.

[48] Kamil had been offered alternative accommodation, but he rejected the option. Kamil also had tenancy rights to remain in Milestones Trust

[49] However, it is not possible to know whether the Crown Prosecution Service (CPS) would have decided that there was sufficient evidence to charge Ian, or whether the police would have made the decision to place him in prison pending a court appearance.

AWP's SI report satisfied its terms of reference and ensured that all key issues and lessons were identified and shared, and that recommendations were appropriate, comprehensive and flowed from the lessons learnt. However, there were several omissions within AWP's SI report. For example:

- Despite it being identified that there were deficits in the risk assessments and care planning undertaken by the assessment and recovery team, the SI authors did not investigate why this had occurred.

- The SI report did not make any specific recommendation with regard to what remedial actions were required within the assessment and recovery team in order to ensure that the highlighted deficits in risk assessment and care planning were addressed.

- The SI authors did not identify or critically review the role of the recovery navigator.

The investigation team were satisfied that AWP's action plan addressed the recommendations from their SI report. However, no evidence has been made available during the course of this investigation to indicate that AWP have in place an ongoing quality assurance process which is evaluating the impact of all the changes that are being introduced as a result of their SI reports (recommendation 14).

Cygnet Health Care's serious incident investigation

Cygnet Health Care's SI report was a comprehensive chronology and review of Ian's inpatient admission. The report met its terms of reference.

Alongside a number of good practices that were identified, four care and service contributory factors were highlighted, and associated recommendations were made.

The investigation team were provided with the most recent action plan and were provided with evidence that indicated all actions have now been completed.

Duty of Candour

AWP

The investigation team were provided with evidence of AWP's contact with Ian's family (Ian's brother) and have concluded that AWP met its duty of candour with regard to notifying Ian's brother. It was reported that Ian's brother had informed the SI author that the extended family did not want to be involved in the SI process.

It was also reported that on two occasions the SI author provided Ian's brother with information about the support that the Patient Advice and Liaison Service (PALS)[50] could offer him.

With regard to Kamil's family, the investigation team concluded that AWP did meet its duty of candour with regard to making contact with them, although at the time of writing this report, the family have only just received a report without redactions, and this significant delay is concerning.

Cygnet Health Care

Cygnet Health Care's SI report stated:

> "This alleged incident occurred after the service user had been discharged and therefore the responsibility of contacting the service user's family will have fallen to other organisations. Due to this being a current police investigation we have been informed that it is not appropriate for us to make contact with the service user's family."[51]

The investigation team did not agree with the decision that it was only AWP's responsibility to contact Ian's family, as the incident occurred less than 12 hours after Ian was discharged from Cygnet Health Care's inpatient unit therefore, they were the most recent provider of care and treatment.

The investigation team suggest that Cygnet Health Care's lack of involvement of the families of both Ian and Kamil in their SI investigation was a significant error, as both would have greatly enhanced the contents and quality of the investigation.

The investigation team also suggest that both AWP and Cygnet Health Care should consider the viability of recruiting a family liaison officer, who would be the single point of contact and provide support for families throughout the serious incident investigation process (recommendation 13).

At Sancus Solutions' six-month quality assurance review, both AWP and Cygnet Health Care must be able to demonstrate that they have a quality assurance process in place that monitors and evaluates the impact of changes that have been made as

[50] The Patient Advice and Liaison Service, or PALS, is an English National Health Service body created to provide advice and support to NHS patients and their relatives and carers . PALS
[51] Cygnet Health Care SI report p4

a result of recommendations from their serious incident investigations (recommendation 14).

Clinical Commissioning Group (hereafter referred to as CCG)

The investigation team were informed that the CCG that has responsibility for monitoring AWP has the following assurance structures in place:

- Monthly Quality Subgroup meetings where serious incidents, themes and trends are discussed.
- Weekly SI panel meetings.
- Integrated performance meetings where incidents are reviewed which have occurred in their commissioned services.
- A representative from the CCG also sits on the safeguarding audit subgroup (SAR). One of the functions of this group is to monitor SARs and associated action plans.

The investigation team were informed that Cygnet Health Care presented their SI action plan to the SAR audit subgroup on 4 February 2019.

However, despite several requests being made at the point of this report being written, AWP have not submitted their latest action plan to either the CCG or the safeguarding audit subgroup.

The investigation team were unable to ascertain why AWP have not been in the position to forward their action plan to their CCG and the safeguarding audit review subgroup (SAR), especially as an action plan was forwarded, on request, to them.

It was reported to the investigation team that one of the major challenges for the CCG has been the fact that there have been significant and repeated personnel changes within AWP's safeguarding adult team. This has resulted in a lack of consistent presence at meetings and a lack of responses to their repeated requests to obtain the SAR and SI action plan. However, it was reported that it is envisaged that with the recent recruitments within AWP, this will be resolved in the near future.

The investigation team were informed that the duty of candour responsibility rests with the provider; therefore, no direct contact was made with Ian's or Kamil's families.

Concluding comments

This is a very tragic event that involved the loss of the life of Kamil, who was a vulnerable adult, who had experienced many significant traumas in his life. His death

will continue to deeply affect the lives of everyone who was involved, but most especially his family. Although the investigation has highlighted some concerning issues with regard to the care and treatment of Ian, it is not suggesting that any one individual practitioner was directly responsible for this tragic event.

Recommendations

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)
Recommendation 1: AWP should review the recovery navigators' induction and ongoing risk assessment training programme to ensure that they have a skill base that is commensurate with the expectations of the role.

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)
Recommendation 2: AWP should introduce a quality assurance process that provides ongoing monitoring of risk assessments and risk management plans that are being completed by the recovery navigators within their assessment and recovery teams.

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)
Recommendation 3**:** AWP should undertake an urgent review of their CPA and Risk Policies to ensure that they provide clarity regarding recovery navigators' responsibilities in relation to care coordination and the assessment of risks.

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)
Recommendation 4: When a patient is receiving support from both a care coordinator and a recovery navigator, regular joint supervision should be undertaken to ensure that an appropriate level of risk assessment and care planning is being provided and to identify when the involvement of a senior clinical practitioner is required.

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)
Recommendation 5: AWP should develop a more comprehensive Risk Summary point in time pro forma.

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)
Recommendation 6: AWP should establish an information sharing protocol between all agencies involved in the provision of services within Bristol Mental Health

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) and Cygnet Health Care
Recommendation 7: AWP should consider the feasibility of allowing Cygnet Health Care's inpatient unit to have access to a patient's AWP records.

Milestones Trust
Recommendation 8**:** Milestones Trust should adopt a comprehensive risk assessment tool that is used by either statutory services or other third sector agencies.

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)
Recommendation 9: Members of the assessment and recovery team should be provided with a continuous professional development session on the role and function of the police's Potentially Dangerous Person (PDP) scheme.

Cygnet Health Care, Avon and Wiltshire Mental Health Partnership NHS Trust (**AWP**), **and Milestones Trust**
Recommendation10: Cygnet Health Cares, AWP's inpatient unit, and Milestones Trust should review their practice with reference to the Triangle of Care's six key elements of carer engagement.

Cygnet Health Care
Recommendation 11: Cygnet Health Care should consider the viability of introducing electronic continuous records in their inpatient units.

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)
Recommendation 12**:** AWP should carry out a review of how the assessment and recovery team undertakes and maintains physical health monitoring of patients who have complex mental health and physical health issues.

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) and Cygnet Health Care
Recommendation 13: AWP and Cygnet Health Care should consider recruiting a family liaison officer, who would be the single point of contact and provide support for families throughout the serious incident investigation process.

Cygnet Health Care and Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)
Recommendation 14: At Sancus Solutions' six-month quality assurance review, AWP and Cygnet Health Care must demonstrate that they have a quality assurance process in place that monitors and evaluates the impact of changes that have been made as a result of recommendations from their serious incident investigations.

1 Events leading up to the incident

1.1 At the time of the incident, Ian and Kamil were both tenants at a mental health supported housing scheme run by Milestones Trust.[52]

1.2 Prior to Ian's admission to the inpatient unit at Avon and Wiltshire Mental Health Partnership NHS Trust (hereafter referred to as AWP) on 13 June 2016, he was being supported by South Bristol Assessment and Recovery Service[53] and Bristol Crisis Service (hereafter referred to as BCS).[54.]

1.3 In November 2015, following a number of amber and red alerts, Ian's atypical antipsychotic medication clozapine[55] was stopped. From this point, there was increasing concern with regard to Ian's mental health and his antisocial behaviours within the supported housing scheme. AWP's assessment and recovery team increased their support, and at times BCS provided additional out-of-hours support.

1.4 4-5 June 2016: Ian disclosed that he was smoking very strong cannabis (skunk[56]) and that his alcohol consumption was increasing. It was also reported by staff at the supported housing scheme that Ian was displaying an escalating pattern of sexualised behaviour towards other tenants and staff.

1.5 8 June 2016: A staff member from Milestones Trust's supported housing scheme reported to the police that CCTV had shown images of Ian exhibiting sexually disinhibited behaviour and entering a female tenant's room uninvited.

1.6 10-12 June 2016:

- 34 notes written by Ian were posted under the staff office door. The contents of the notes included delusional ideation, comments on Ian's current state of mind, graphic sexual references, references to the mental illness of other

[52] Milestones Trust is a charity that supports people with learning disabilities, mental health needs and dementia in Bristol Milestones Trust

[53] South Bristol Recovery Service (Recovery Service), provided by AWP, is a community mental health team that provides secondary-level mental health assessment, support, treatment and care coordination under the Care Programme Approach (CPA) Recovery Service

[54] The Bristol Crisis Service (BCS), provided by AWP, operates a 24-hour service, 7 days a w eek, 365 days a year. Service users requiring "emergency" (within 4 hour) assessments will be transferred to the BCS by their GP; they can self -refer or be referred by family/friends, the Liaison/Court Diversion Service, the mental health liaison service, police and ambulance staff , and others. In a crisis, the BCS endeavour to engage and support anyone needing immediate and intensive input.

[55] Clozapine is an atypical antipsychotic that is used for treatment-resistant schizophrenia. The drug is subject to strict monitoring requirements because it is associated with serious side effects, such as neutropenia, agranulocytosis, leukopenia (lowered white blood cell count), myocarditis (inflammation of the heart muscle) and cardiomyopathy. Patients newly started on clozapine must have a full blood count (FBC) taken weekly for the first 18 weeks of treatment and then fortnightly for the next 34 weeks. After that, they receive monthly monitoring for as long as they are taking clozapine. Amber result: clozapine can be dispensed, but FBC must be monitored twice a w eek. Red result: stop clozapine and monitor FBC daily until results return to normal NICE guidelines

[56] Skunk

tenants, and threats to kill named tenants, including Kamil, and members of the public. The supported housing staff reported the contents of the notes to the police and members of AWP's BCS.

- BCS referred Ian to the Emergency Duty Team (hereafter referred to as EDT)[57], requesting that a Mental Health Act 1983 assessment be undertaken.

- The supported housing scheme staff agreed a contingency plan for the management of Ian over the weekend with Milestones Trust's staff team, which included no lone working at the service. Milestones Trust's staff reminded the other tenants of the importance of not permitting anyone uninvited into their accommodation and gave them the contact details of the emergency services. Unsuccessful attempts were made to contact Kamil, who was, at the time, away from the service.

- Over the weekend, due to difficulties in securing a hospital bed and a difference of opinion between BCS and EDT with regard to Ian's mental health and risk factors, the Mental Health Act 1983 assessment was postponed.[58] BCS continued to provide support to Ian.

1.7 13 June 2016: After police reviewed the CCTV footage at the supported housing scheme Ian was arrested on suspicion of threats to kill and indecent exposure. While in custody, Ian was assessed by the duty Mental Health Team and detained under a Section 2[59] of the Mental Health Act 1983. He was placed in AWP's Psychiatric Intensive Care Unit (hereafter referred to as PICU).[60] Charges against Ian deferred.

1.8 20 June 2016: As part of AWP's ongoing bed management, Ian was transferred to Cygnet Health Care PICU unit.[61] Ian's admission was reported to be uneventful, and he was reportedly fully compliant with his medication regime.

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[57] The Emergency Duty Team provides an emergency social work service for the four authorities of Bath and North East Somerset, Bristol, North Somerset, and South Gloucestershire at night, at weekends and on bank holidays. One of the roles of the EDT is to provide out-of-hours Approved Mental Health Practitioners (AMHPs) to arrange Mental Health Act 1983 assessments. EDT

[58] See Section 3 for analysis

[59] Section 2 of the Mental Health Act 1983: a patient can be kept in hospital for up to 28 days. Aim of the admission is to allow time for assessment and diagnosis and, if required, commence treatment. A patient has the right to appeal the section within the first 14 days. Section 2

[60] AWP's PICU inpatient unit is a 12-bedded unit patients are mostly presenting with acute psychotic and behavioural dysregulation unmanageable on other units or in the community. The majority of care offered is intensive and seeks to stabilise patients with medication, support and therapy, with a view to helping them step down onto a less supported open ward, as their care needs become less intense. AWP PICU

[61] Cygnet Health Care's PICU unit was located outside of the Bristol locality. The hospital is a 70-bedded low-secure psychiatric hospital, consisting of five wards. The hospital is registered to provide treatment of disease, disorder and injury, and assessment or medical treatment of people detained under the Mental Health Act 1983. A management agreement was in place between Cygnet Health Care and AWP to provide additional beds for AWP patients. As a response to this incident, this agreement has been reviewed.

1.9 28 June 2016: A Mental Health Tribunal was convened. The tribunal panel was advised that due to concerns regarding the suitability of Ian's accommodation, it was the housing provider's intention to service him with a Notice to Quit.[62] The tribunal panel agreed to a delay in the date of Ian's section being discharged to allow time for a discharge planning meeting to be convened.

1.10 6 July 2016:

- 4pm: One of Ian's brothers collected him from the inpatient unit and dropped him off at the supported housing scheme.

- Evidence presented at Ian's trial reported that he then left the supported housing scheme and during the evening visited several pubs, where he consumed a large quantity of alcohol.

1.11 7 July 2016:[63]

- 1.30am: Ian telephoned the on-call BCS, stating that he had drunk a litre of rum and "felt like punching an Asian resident who lived in the same accommodation"[64].

- It was documented that Ian became angry when told by the member of the BCS staff that he would be held responsible for his actions. Ian replied that he was "insane and wasn't responsible"[65] and then ended the call. Ian did not answer the phone when a member of BCS staff tried to call him back.

- 20:00am (approximately): BCS telephoned the police using the 101 non-emergency number[66] to inform them about Ian's threat.

- 2.10am (approximately): Ian telephoned the police to report that he had killed Kamil.

1.12 At the trial, Ian was found guilty of the murder of Kamil and given a life sentence. He is currently being detained in a high-security hospital.

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[62] A notice to quit is the notice that has to be served by a landlord, requesting that the tenant leaves their accommodation by a certain date (usually 30 days). If a tenant does not leave the property by the end of this notice period, the landlord must take action in court to have them evicted.

[63] CCTV evidence from the supported housing scheme showed Ian entering Kamil's flat in possession of a knife

[64] AWP progress notes 7 July 2016

[65] AWP progress notes 7 July 2016

[66] The police non-emergency number. 101 is the number to call when a person needs to contact their local police about a non-urgent crime. 101

Mental health diagnosis and medication

1.13 At the age of 26 years, Ian was given the mental health diagnosis of paranoid schizophrenia – ICD code[67] F20.

1.14 At the time of Ian's discharge from Cygnet Health Care's inpatient unit, his mental health medication regime was:

- Risperidone depot injection 50mg[68] (every two weeks)
- Quetiapine 100mg[69] (at night)
- Diazepam 5mg[70] (three times a day as required)
- Clonazepam 2mg[71] (daily)[72]

2 Independent investigation

2.1 From 2013 NHS England assumed overarching responsibility for the commissioning of independent investigations into mental health homicides and serious incidents. On 1 April 2015, NHS England introduced its revised Serious Incident Framework[73], which aims:

"To facilitate learning by promoting a fair, open and just culture that abandons blame as a tool and promotes the belief that an incident cannot simply be linked to the actions of the individual healthcare staff involved but rather the system in which the individuals were working. Looking at what was wrong in the system helps organisations to learn lessons that can prevent the incident recurring."[74]

2.2 The criteria for the commissioning of an independent mental health homicide investigation are:

"When a homicide has been committed by a person who is, or has been, in receipt of care and has been subject to the regular or enhanced care

[67] Statistical Classification of Diseases and Related Health Problems (ICD) ICD

[68] Risperidone is an atypical antipsychotic that is used to treat symptoms of schizophrenia. The medication is also sometimes used to treat symptoms of bipolar disorder. NICE guidelines

[69] Quetiapine is an atypical antipsychotic used for the treatment of schizophrenia, bipolar disorder and major depressive disorder. NICE guidelines

[70] Diazepam: a benzodiazepine medication used for sleep, anxiety and muscle spasms . NICE guidelines [71] Clonazepam belongs to a class of drugs called benzodiazepines. This medication was added to Ian's medication regime during his admission to Cygnet Health Care's inpatient unit

[72] NICE licensed to treat panic disorders (NICE guidelines). There was no indication that the changes made to Ian's prescribed medication were discussed with any of the involved AWP's consultant psychiatrists.

[73] NHS Serious Incident

[74] NHS Serious Incident p10

programme approach or is under the care of specialist mental health services, in the 6 months prior to the event."[75]

2.3 The Serious Incident Framework cites that a standardised approach to the investigation of such incidents is to:

"Ensure that mental health care related homicides are investigated in such a way that lessons can be learned effectively to prevent recurrence. Facilitate further examination of the care and treatment of the patient in the wider context and establish whether or not an incident could have been predicted or prevented, and if any lessons can be learned for the future to reduce the chance of recurrence. Ensure that any resultant recommendations are implemented through effective action planning and monitoring by providers and commissioners."[76]

2.4 NHS England (North) commissioned Sancus Solutions (hereafter referred to as the investigation team) to undertake an investigation into the care and treatment of Ian by the involved primarily, secondary and third sector services.

Purpose and scope of the investigation

2.5 The full Terms of Reference (ToR) for this investigation are located in Appendix A.

2.6 The overall purpose of this investigation is:

"To identify whether there were any gaps, deficiencies or omissions in the care and treatment that [Ian] 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 … Review the quality of assessment and treatment plans that were provided by all NHS provider organisations and including, non-NHS organisations identified in the level 2 investigations from August 2015."[77]

2.7 The Terms of Reference also asked the investigation team to consider: "If this incident was predictable, preventable or avoidable"[78]. For the purpose of this investigation, the investigation team have used the following definitions:

- Predictability: the probability of violence, at that time, was high enough to warrant action by professionals to try to avert it.[79]

[75] NHS Serious Incident p47
[76] NHS Serious Incident p48
[77] NHS England ToR p1
[78] NHS England ToR p2

- Preventability: a preventable incident is one for which there are three essential ingredients present: the knowledge, legal means and opportunity to stop an incident from occurring.[80]

- As, at this time, there is no agreed definition of an avoidable homicide, for the purpose of this investigation Sancus Solutions will be using the following Learning Disability Mortality Review Programme's definition of an avoidable death:

  "Where there are aspects of care and support that, had they been identified and addressed, may have changed the outcome and on balance of probability the person may have lived for another year or more"[81].

2.8 The investigation team will submit a written report to NHS England (South) that includes measurable and sustainable recommendations. The report will assign recommendations to the relevant organisation as well as highlighting any areas that require national NHS England and NHS Improvement[82] action(s).

2.9 The investigation team will also:

"Deliver learning events/workshops for the Trust, staff and commissioners as appropriate … 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."[83]

Sancus Solutions' investigation methodology

2.10 As far as possible and throughout the course of their investigation, Sancus Solutions' investigation team aimed to eliminate and/or minimise hindsight or

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[79] 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. Predictability is "the quality of being regarded as likely to happen, as behaviour or an event". We will identify if there were any missed opportunities which, if actioned, may have resulted in a different outcome. 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. Predictability

[80] Preventability – to prevent means to "stop or hinder something from happening, especially by advance planning or action" and implies "anticipatory counteraction"; therefore, for a homicide to have been preventable there would have to have been the knowledge, legal means and opportunity to stop the incident from occurring

[81] The National Learning Disability Mortality Review Programme is working with other agencies, such as the Learning Disability Public Health Observatory and the Transforming Care (Winterbourne View) Improvement Programme, to reduce health inequalities faced by people with learning disabilities. Learning Disability Mortality Review Programme Avoidable deaths

[82] NHS Improvement (NHSI) is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. NHS Improvement

[83] NHS England ToR p3

outcome bias.[84] However, where hindsight has informed the interviewees' recollections or the investigation's judgements, this has been identified.

2.11 As this investigation was commissioned by NHS England, the primary focus will be on the care and treatment of Ian by AWP and Cygnet Health Care services. However, where relevant the investigation team will review and comment on any other involved services, such as Milestones Trust and the primary care service.

2.12 Both Cygnet Health Care and AWP completed a serious incident reports (hereafter referred to as SI) which made a number of recommendations. Action plans were developed by both agencies. As part of this investigation, the investigation team will be reviewing and commenting on the quality of AWP's and Cygnet Health Care's SI reports and also the implementation of their respective action plans.

2.13 Following this incident, Bristol Safeguarding Adults Board[85] (hereafter referred to as BSAB) commissioned an independent review (hereafter referred to as SAR),[86] which was published in June 2016.The SAR focused on the involved services with regard to both Ian and Kamil. As part of the SAR, the involved agencies submitted reports and the investigation team were given access to both Milestones Trust and United Communities Housing Association (hereafter referred to as UCHA)[88]. It is the investigation team's intention not to duplicate these post-incident investigations but to identify and provide further commentary and analysis on the care and treatment of Ian and to review the progress agencies have made on their SAR action plans.

2.14 Details of Sancus Solutions' investigation team are located in appendix c.

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

[85] The Bristol Safeguarding Adults Board is responsible for ensuring that organisations in the city are working effectively to make sure that adults are safe from abuse and harm. Bristol Safeguarding Adults Board

[86] The Care Act 2014 states that Safeguarding Adults Boards must arrange a Safeguarding Adults Review (SAR) when an adult with care and support needs dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. Safeguarding Adult Boards must also arrange an SAR if an adult in its area has not died, but the Board knows or suspects that adult has/is experiencing serious abuse or neglect.

[87] SAR report

[88] United Communities were the housing management agency that provided advice and management of tenancies for Milestones Trust

Interviews

2.15 Sancus Solutions' interviews are managed with reference to the National Patient Safety Agency (NPSA) investigation interview guidance.[89] Where there has been the potential for perceived criticism of individuals or their actions, we have adhered to the Salmon/Scott principles.[90]

2.16 Details of who was interviewed as part of this investigation are located in appendix D.

2.17 For the purposes of this report, the identities of all those who were interviewed have been anonymised and they have been identified by their professional titles.

2.18 Sancus Solutions' investigators obtained and reviewed evidence from:

- AWP and Cygnet Health Care's patient records
- Primary care service's patient records
- AWP and Cygnet Health Care's SI reports
- Milestones Trust's tenant records for Ian and Kamil
- BSAB's SAR
- Milestones Trust and UCHA's reports prepared for SAR
- AWP and Cygnet Health Care's policies and procedures that were in place at the time of the incident, as well as those that have subsequently been reviewed.

References are also made to national best practice guidelines and governmental strategies, which are referenced in the respective footnotes and in appendix A.

3 Involvement of the families

"Meetings with the victim and perpetrator families and the perpetrator to seek their involvement in influencing the terms of reference. Assist the family in the production of an impact statement for inclusion in the final published report, if appropriate."[91]

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

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

[91] NHS England ToR p2

3.1 NHS England's Serious Incident Framework directs that all investigations must:

> "Ensure that families (to include friends, next of kin and extended families) of both the deceased and the perpetrator are fully involved. Families should be at the centre of the process and have appropriate input into investigations."[92]

3.2 Throughout the course of all Sancus Solutions' investigations, they will always try to seek the views of the families of both the victim and the perpetrator, not only in relation to the incident itself, but also to ascertain their wider thoughts regarding where improvements to services can be made in order to prevent similar incidents from occurring.

3.3 At the time of writing this report, NHS England and the investigation team have been unable to engage with Ian's family.

3.4 NHS England's Head of Investigations (Mental Health Homicides) and the investigation team met with members of Kamil 's family and discussed the purpose of the investigation and the draft Terms of Reference.

3.5 It was agreed with Kamil's family that the following term of reference was to be included:

> "Review and assess the quality of all clinical risk assessment to determine if Ian posed specific risks to the victim based on their ethnicity, gender, race, religion or culture. If risks of this nature were identified were they formulated as potential Hate Crimes and were appropriate steps to mitigate/address those risks taken."[93]

3.6 It was explained to Kamil's family that unlike the SAR the focus of this investigation is not on the support offered to Kamil but on the care and treatment provided to Ian by AWP, Cygnet Health Care, the primary care service and the involved third sector agency, Milestones Trust. It does however address the management of the incidents that occurred between Ian, Kamil and other tenants.

3.7 Kamil's family have been invited to write a personal statement.

3.8 The families of Ian and Kamil will also be offered the opportunity to receive and comment on the final report. If they wish, Sancus Solutions' lead investigator will meet with them to provide verbal feedback on the report's

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

[93] NHS England ToR p1

findings and recommendations. They will also have the opportunity to meet with representatives from the trust and their commissioner to discuss their responses to the report's findings and recommendations.

3.9 The families will also be invited to receive a copy of Sancus Solutions' quality assurance report, which will be undertaken six months after the report has been published. This report will evaluate the progress the involved services have made on implementing their action plan.

Structure of the report

The report is divided into the following sections:

- Section 1 provides a brief overview of Ian's familial, forensic and mental health histories from 1977 to 2014.

- Section 2 provides a narrative chronology of events from 2015 to the incident on 7 July 2016.

- Section 3 addresses particular NHS England terms of reference and other key lines of inquiry that Sancus Solutions' investigation team have identified in the course of their investigation.

- Section 4 will critically review the involved agencies' SI reports and their compliance with the required Duty of Candour[94] both post incident and throughout their SI investigations. Sancus Solutions will also comment on the progress AWP and Cygnet Health Care have made in their implementation of their SI reports' action plans.

- When a section refers to a particular NHS England Term of Reference, this will be identified at the beginning of the section.

Section 1

4 Ian's background

4.1 There is little documented information regarding Ian's childhood except that he was a twin and had nine siblings. He left school at the age of 16 with no educational qualifications and was then sporadically employed as a labourer, painter and decorator.

[94] Duty of candour is a legal requirement for health, care service and social work organisations to inform people (and their families) when they have been harmed (either physically or psychologically) as a result of the care or treatment they have received. 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 providing an apology when things go wrong. Duty of Candour

4.2 It was documented that Ian reported that he first began to experience paranoid thoughts at the age of 16, particularly concerning his father[95], which coincided with him beginning to drink excessive amounts of alcohol.

4.3 At the age of 18 Ian began a relationship and had a child. In 2005 Ian reported[96] that this relationship had ended due to his alcohol consumption, which had significantly increased.

Psychiatric and forensic history

1977-2009

4.4 From 1977[97] to 1984, Ian was convicted of 18 offences, including shoplifting, criminal damage, property offences and assault.

4.5 Ian's first contact with community psychiatric services was in 1983, when he presented with some paranoid thoughts about his co-workers and reported that he was experiencing suicidal ideation. It was documented that he was drinking up to 14 pints of beer a day at that time.

4.6 Ian subsequently disengaged from community mental health services. In 1984, while he was serving a 15-month prison sentence for robbery and assault, he was assessed by the prison's psychiatric service, as he was presenting with hallucinations and persecutory thoughts.

4.7 On his release from prison, Ian was seen by the community mental health team and was prescribed a depot[98] of antipsychotic medication.

4.8 Ian again disengaged from community mental health services until 1986, when his probation services made a referral. Ian reported that he was experiencing violent thoughts towards others.

4.9 During 1987 Ian was presenting with increasingly psychotic symptoms, and in June he was arrested after he had broken into a GP's surgery. He reported he had wanted to get arrested in order to obtain accommodation. Ian subsequently broke a glass door at the police station. He was subsequently made subject to a Probation Order, with a condition that he engaged with community psychiatric treatment.

4.10 In September 1987 Ian became non-compliant with his medication regime and was admitted to hospital. During this admission, there was a serious incident in which Ian attacked a number of the nurses and was transferred to prison.

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[95] AWP care assessment 5 July 2005

[96] AWP care assessment 5 July 2005

[97] Ian was 16 years old

[98] Depot injection is a slow-release, slow-acting form of medication

Ian disclosed that he was experiencing command auditory and delusional hallucinations and paranoid thoughts that were telling him to attack people in authority and other prisoners. Ian was given a diagnosis of a chronic paranoid schizophrenic illness.[99] It was documented that his symptoms were being exacerbated by his ongoing alcohol abuse, which was resulting in disinhibited and aggressive behaviours.

4.11 It was documented in a later AWP risk summary[100] that it was suspected that in September 1987 Ian had started a fire; however, no further information was documented in any subsequent assessments.

4.12 6 May 1988: Ian was committed to a high-secure hospital under Section 37 of the Mental Health Act 1983[101], with a Restriction Order under Section 41 Without Limit of Time.[102] It was documented in a psychiatric report (1991) that:

> "Although [Ian's] index offence was trivial the Restriction Order was recommended because of his dangerousness in terms of his psychotic ideas about doctors and prison staff and his threats to kill them."[103]

4.13 During his admission, it was documented that Ian had historically responded well to clozapine (300mg) and that his symptoms had reduced. It was also documented that when the clozapine had been stopped, due to adverse side effects, Ian's mental health symptoms rapidly returned.

4.14 April 1989: A Mental Health Tribunal gave Ian a Deferred Conditional Discharge[104] and he was released to a probation hostel. However, following two breaches in his conditions, involving being absent without leave, he was recalled to the high-secure hospital (1989). In 1990 Ian was transferred to a regional secure unit.[105]

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[99] Schizophrenic illness

[100] AWP risk summary 16 December 2013

[101] Where the Crown Court has made a Section 37 Hospital Order, it may also impose restrictions on a patient's discharge. Before they make such an order, they must be satisfied that it is necessary to do so to protect the public from serious harm. It means that a patient cannot be discharged from hospital unless the Ministry of Justice or a Tribunal grants permission that a patient can be discharged. The discharge may be subject to certain conditions.

[102] Section 41 is also called a "restriction order". An appeal to the Mental Health Tribunal can be made once in the first 12 to 24 months after the conditional discharge and then once in every two-year period after that. Section 41

[103] Psychiatric report December 1991 p15

[104] A deferred conditional discharge decision is a provisional decision to conditionally discharge a patient, pending the Tribunal being satisfied that suitable arrangements have been put in place to enable the conditions of discharge to be met Deferred Conditional Discharge

[105] The regional secure unit was an AWP service, so the paper records would have been available to AWP staff who were supporting Ian in the years leading up to the incident. The community mental health staff reported that they did not access them.

4.15 June 1991: Following a serious assault on a member of the nursing staff at the regional secure unit, which involved the use of a weapon, Ian pleaded guilty to the offence and was admitted back to a high-secure hospital, where he remained until 1996. He was then transferred to another high-secure hospital.

4.16 In 2001 Ian was transferred to a regional secure unit, where he underwent a rehabilitation programme. There were no significant incidents documented during this period.

4.17 29 April 2008: A Mental Health Act Tribunal granted Ian a conditional discharge, as Ian had been detained under section 37/41 of the Mental Health Act 1983. The local authority had, at the time, a statutory duty to provide Section 117 aftercare[106], which funded Ian's placement in one of Milestones Trust's registered care homes. There were no reported incidents during this placement.

5 2010 to 2014

5.1 2 June 2010: Ian was granted an absolute discharge by a Mental Health Tribunal. After it was assessed that Ian no longer required the intensive support provided by the care home, he moved into one of Milestones Trust's supported housing scheme services.

5.2 17 June 2012: An AWP care plan was completed.

5.3 February 2013: Ian was being prescribed the atypical antipsychotic medication clozapine[107], and routine blood tests began to report an amber result.[108]

5.4 5 March 2013: AWP's care plan was reviewed.[109]

5.5 19 September 2013: Ian's clozapine was stopped due to his blood results showing red.[110] Ian was initially prescribed another antipsychotic medication,

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[106] Section 117 of the Mental Health Act says that aftercare services are services which are intended to: meet a need that arises from or relates to a patient's mental health problem; reduce the risk of their mental condition getting worse; and reduce the risk of the patient having to go back to hospital. This can include funding for housing, direct payments for support and free prescriptions. Duty of responsibility for funding now lies w with the Clinical Commission Group (CCG) and the Local Authority/social services. Section 117

[107] The drug is subject to strict monitoring requirements because it is associated with serious side effects, such as neutropenia, agranulocytosis, leukopenia (lowered white blood cell count), myocarditis (inflammation of the heart muscle) and cardiomyopathy. Patients newly started on clozapine must have a full blood count (FBC) taken weekly for the first 18 weeks of treatment and then fortnightly for the next 34 weeks. After that, a patient must receive monthly monitoring for as long as they are taking clozapine. NICE guidelines

[108] Amber result: Clozapine can be dispensed but monitoring of full blood count twice a week is required. NICE guidelines

[109] This w as the last care plan completed

[110] Red result: immediately cease taking clozapine. Monitor full blood count daily until results return to normal. NICE guidelines

Amisulpride[111], but due to him experiencing side effects, this was changed to another atypical antipsychotic medication, Quetiapine[112] (7 November 2013).

5.6 By October 2013 it was being reported that Ian was exhibiting fluctuating psychotic symptoms, including paranoid auditory hallucinations, agitation, aggression and sexual disinhibition. It was documented that the latter was precipitated by Ian's increased alcohol consumption. A referral was made to AWP's Intensive team.

5.7 19 October 2013: Ian disclosed that he "occasionally had thoughts to shoot residents with a gun"[113]. He reported that as he did not have access to a gun, it was documented that it was "very unlikely that [Ian] would act on these thoughts"[114].

5.8 From October 2013 to 15 December 2013, there were three incidents that involved Ian and other tenants. Two of these incidents involved Kamil.

5.9 3 December 2013: AWP's Intensive team withdrew their support, as it was assessed that Ian was "relatively stable"[115]. Support continued to be provided by his AWP care coordinator and the staff at the supported housing service.

5.10 10 December 2013: Ian's AWP risk summary assessed that his overall risk to others was medium.

5.11 16 December 2013: It was decided that due to Ian's increasing psychotic presentation, he would be admitted to the inpatient unit in order to restart his clozapine medication. However, Ian refused admission as an informal patient, and following his arrest for an assault on Kamil (15 December 2013) and at the request of his consultant psychiatrist, a Mental Health Act 1983 assessment was convened. Ian was placed under a Section 2[116] of the Mental Health Act 1983.

5.12 Ian's risk summary, which was completed during this inpatient admission, assessed that both his risk of harm to others and his overall risk rating were high. During this admission, it was documented that Ian had disclosed racist feelings towards Kamil.

5.13 There was no documented evidence that any further risk assessments were undertaken during Ian's admission to hospital or prior to his discharge, butit

[111] Amisulpride: antipsychotic medication. Amisulpride

[112] Quetiapine is an atypical antipsychotic used for the treatment of schizophrenia, bipolar disorder and major depressive disorder. Quetiapine

[113] Letter to Ian from the Intensive team 22 October 2013

[114] Letter to Ian from the Intensive team 22 October 2013

[115] Discharge letter to Ian, 3 December 2013. Copies of all correspondence were sent to Ian's GP but not the supported housing scheme.

[116] Section 2 of the Mental Health Act 1983 – a patient can be detained for up to 28 days. Section 2

was documented in his progress notes that his historic risks to others remained "static".

5.14 On his admission, Ian gave written consent for the inpatient unit "to share information about his care and treatment with significant others"[117].

5.15 During this admission, Ian was also allocated a new care coordinator from the community mental health team.

5.16 30 December 2013: Ian's section 2 of the Mental Health Act 1983 was rescinded, but he remained an informal patient until 29 January 2014, at which point he returned to the supported housing scheme. His discharge medication regime was clozapine 150mg and the antidepressant Venlafaxine 75mg[118] "for anxiety"[119].

5.17 In the discharge summary, which was sent to the GP, it was documented that Ian was "dangerous when he [was] unwell"[120]. It was also documented that a community forensic opinion was to be obtained in order to review Ian's accommodation and long-term treatment plan.

5.18 After his discharge, Ian was visited weekly by the community recovery team to deliver his medication and to monitor his progress and the situation with Kamil and the female tenant.

5.19 5 February 2014: Ian's care coordinator emailed the local forensic unit requesting a forensic assessment.

5.20 5 March 2014: A Community Programme Approach (CPA) review was convened. It was documented that Ian's mental health was stable, he was compliant with his medication and there had been no further incidents involving other tenants.

5.21 However, by April 2014 it was being documented that Ian had missed several blood tests, and the supported housing scheme staff were reporting to the care coordinator that Ian's "behaviour was reverting to that of antagonising other residents, non-compliant with link working and drinking excessively"[121].

5.22 9 March 2014: At a CPA review, the supported housing scheme's manager reported that she felt that Ian "was inappropriately placed … and if he continued to upset the other residents, she would give him notice"[122]. Ian

[117] Information Sharing and Consent form 18 December 2013
[118] Venlafaxine is used to treat major depressive disorder, generalised anxiety disorder, panic disorder and social phobia. Venlafaxine
[119] Discharge summary January 2014 p3
[120] Discharge summary January 2014 p2
[121] AWP progress notes 17 April 2014
[122] AWP progress notes 9 March 2014

agreed to be referred to a local Recovery Orientated Alcohol and Drug Service (ROADS)[123]. It was also agreed that a referral would be made to social services, who would secure him alternative accommodation.[124]

5.23 By July 2014, the care coordinator documented that he had reduced his visits to monthly and Ian's support was being provided by a recovery navigator [125] the role of recovery navigator will be addressed in section 3.

5.24 Ian's mental health was reported as being stable, and he was reported to be compliant with his medication regime.

5.25 No further incidents involving Ian and other tenants were documented for the rest of the year, although it was documented that he was consistently not engaging with the support offered to him by the supported housing staff.

Section 2

This section will provide a detailed narrative chronology of the key events from 2015 to the incident (7 July 2016).

6 2015

- 16 January 2015: Ian met with his consultant psychiatrist, and it was documented that his mental health was stable and there were no significant incidents reported involving Ian in the supported housing scheme. Ian also reported that he was regularly drinking six cans of beer at the weekend and that he was concerned about the increase in his weight.

6.1 26 January 2015:

- Ian's blood test reported an amber result.
- A follow-up blood test reported a green result and Ian's clozapine medication continued.

6.2 30 March 2015:

- Ian was transferred to an AWP recovery navigator. One of the main roles of the recovery navigator was to deliver Ian's clozapine to him. Ian's risk summary, crisis plan and core assessment overview were updated.

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[123] ROADS

[124] There was no further documented evidence to indicate that any further actions were taken following this meeting with regard to securing alternative accommodation or engaging Ian with support services in order to reduce his alcohol issues

[125] Recovery navigators work with service users to give support and advice and help plan their recovery with them throughout their journey. Recovery navigators

- The overview documented that Ian's ongoing risks of violence and aggression to others were usually in the context of paranoid thinking and his alcohol consumption. The risk summary documented that Ian was "aware that alcohol [could] be a trigger"[126]. His overall risk rating was assessed as medium.

- It was also documented that Ian was "encouraged to approach staff for on-going support should [he] begin to notice signs of irritability or anger"[127].

6.3 May 2015: Ian was reporting to his recovery worker that his alcohol intake had increased in the last three months, and although he was only drinking at weekends, he was consuming eight cans of strong lager and half a bottle of vodka. It was documented in his care assessment overview that Ian felt that his drinking was "problematic … he does not become aggressive but [was] worried that this pattern might lead to alcoholism"[128]. It was suggested to Ian that he should begin a reduction programme.

6.4 1 June 2015: Ian's blood test results reported an amber result; a further blood test reported a green result, so his clozapine continued.

6.5 7 July 2015: Ian was reviewed by his consultant psychiatrist. A discussion took place regarding Ian's alcohol consumption. It was documented in a subsequent letter to Ian from the consultant psychiatrists that although it was evident that Ian:

"recognised the physical health problems that drinking too much on a Friday and Saturday night [can] have, your enjoyment of being slightly intoxicated is such that you look forward to it … and would be very unlikely to change this pattern which you have done for many years. You feel it doesn't have detrimental effects on your mental health and no strong incentive to change this."[129]

6.6 5 August 2015: The recovery navigator was informed that Ian had two further amber blood test results.

6.7 19 August 2015: Ian's blood test reported a green result.

6.8 16 September 2015: Ian's blood test reported an amber result.

6.9 1 October 2015: The recovery navigator documented that she had concerns that Ian was not fully compliant with his clozapine regime, as he was reporting that he had unused medication, which contradicted the dispensing scheduled.

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[126] Care plan overview 16 March 2015
[127] Care plan overview 16 March 2015
[128] Core assessment entry 27 May 2015
[129] Letter to Ian 7 July 2015, cc'd to Ian's GP

- 13 November 2015: A Care Planning Approach (CPA) review was undertaken by the recovery navigator. The recovery navigator and a new consultant psychiatrist visited Ian.

- It was documented that there were no concerns with regard to Ian's placement or his mental health. It was agreed that the recovery navigator's support would continue and that Ian would have a review in six months.

6.10 19-21 November 2015:

- Following a red-alert blood result, the decision was made to stop Ian's clozapine.

- The recovery navigator and another member of the team visited Ian at the supported housing scheme in order to remove all the unused medication.

- Ian was informed that he was to have daily blood tests and that he would not restart clozapine until he had two green results.

- Ian's support plan was revised and it was documented that over the weekend, Ian would be visited by the weekend duty team.

- There was documented evidence of ongoing liaison between the dispensing pharmacist and Ian's GP with regard to arranging for blood tests to be undertaken over the weekend.

6.11 23 November 2015: Ian's blood test reported an amber alert.

6.12 24 November 2015: Ian's historic patient records were requested so that a medication review could be undertaken by the consultant psychiatrist.

6.13 26 November 2015: There was ongoing telephone contact between Ian's recovery navigator and the supported housing scheme staff, during which Ian's mental health presentation was discussed.

6.14 27 November 2015:

- Ian's blood test reported an amber alert.

- Ian had a scheduled appointment with the consultant psychiatrist. During the appointment Ian disclosed that he had, at times, not been taking his clozapine, so that he could drink alcohol.

- It was agreed that Ian would commence the antipsychotic risperidone, initially at 2mg, with a titration plan to increase it to 4mg nocte[130] in three days, at which point it would be administered as a depot injection.[131]

- In a letter to Ian's GP, the consultant psychiatrist suggested that this form of administering risperidone would enable monitoring of Ian's ongoing compliance.

6.15 28 November 2015: Ian was visited by the care coordinator and recovery worker.

6.16 30 November 2015:

- The consultant psychiatrist wrote to Ian's GP and requested that the surgery undertake a "full annual health check [as Ian] had not had one before"[132].

- The GP was informed that in order to monitor for any signs of a relapse in Ian's mental health, the consultant psychiatrist and the recovery navigator would see him weekly. The GP was also advised that Ian still required weekly blood tests.

- The recovery navigator documented that she had spoken to the supported housing manager, who reported that the team suspected that Ian's alcohol consumption was higher than he was disclosing and that the team had observed an increase in his paranoid thinking.

- The recovery navigator informed the supported housing manager that she was aware of Ian's risk history and advised that the service should call the police if there was an incident involving Ian and the other residents.

6.17 2 December 2015: Ian was visited by a duty specialist recovery practitioner and the recovery navigator. It was documented that Ian was presenting as stable.

6.18 4 December 2015:

- The consultant psychiatrist visited Ian at his accommodation. It was documented that Ian remained "stable"[133] and that his most recent blood test (3 December 2015) was a green result.

[130] Nocte: every night
[131] Depot injection: slow-release, slow-acting form of medication
[132] Letter to GP 30 November 2015
[133] AWP progress notes 4 December 2015

- Ian agreed to an increase in his risperidone to 5mg nocte, and due to him reporting difficulty in sleeping, he was also prescribed a short course of zopiclone[134] 7.5mg nocte.

- It was documented that there were no concerns reported by the supported housing scheme's staff.

6.19 6 December 2015: In a telephone call with the recovery navigator, Ian reported that he was going to the hospital to have an ECG, as his GP surgery did not have this facility.

6.20 9 December 2015: The recovery navigator and duty worker visited Ian, and it was documented that Ian was presenting as "calm … euthymic"[135].

6.21 10 December 2015:

- During a visit, the recovery navigator documented that a member of the support housing scheme's staff had expressed their concern "that [Ian] was not himself"[136]. It was also documented that Ian had:

  "Mentioned Kamil recently … no threats made but last time [Ian] was unwell he assaulted Kamil … However, he did go on and talked about Kamil and some of the issues he had had with him."[137]

- It was also documented that during the visit, Ian had exhibited "disinhibition/sexually oriented language"[138]. The recovery navigator documented that she had:

  "Checked arrangements regarding the communal lounge in respect to potential risks, it is no longer appropriate for staff to be seeing [Ian] in his room (small space and not easy to get out)"[139].

- The recovery navigator also discussed her observation from the visit with the consultant psychiatrist, who then contacted Ian by phone. During the call, Ian denied that he was drinking alcohol, having any paranoid thoughts or having "any thoughts to harm self or others"[140].

[134] Zopiclone is a non-benzodiazepine hypnotic agent used in the treatment of insomnia. Zopiclone
[135] AWP progress notes 9 December 2015. Euthymic: normal, tranquil mental state or mood
[136] AWP progress notes 10 December 2015 12pm
[137] AWP progress notes 10 December 2015 3.30pm
[138] AWP progress notes 10 December 2015 3.30pm
[139] AWP progress notes 10 December 2015
[140] AWP progress notes 10 December 2015 7pm

- The consultant psychiatrist agreed with Ian that his risperidone would be increased to 6mg nocte, and he was also prescribed diazepam[141] 2mg prn.[142]

- It was documented that the BCS were to visit Ian and that they had been advised:

  "To go in pairs … low threshold for admission MHA assessment[143] if indication of risk increasing, in particular risk to others."[144].

6.22 11 December 2015: Ian's risk summary and crisis plan were updated by the recovery navigator.

6.23 12 December 2015:

- Two members of the BCS visited Ian in order to undertake an assessment. It was documented in Ian's patient records:

  "Risk to others: when asked about his relationship with other residents in [the] supported accommodation [Ian] made particular reference to another service user but denied thoughts/plans."[145]

- It was agreed that the BCS would visit Ian daily.

6.24 16 December 2015: A letter was sent to Ian's GP advising that the BCS team intended to support Ian for a short period of time.

6.25 13 December to 30 December 2015: BCS, the care coordinator and the recovery navigator were all involved in visiting Ian over the Christmas period.

16 December 2015: The following concerns/plans were documented:

- Ian disclosed "some preoccupation with thoughts /ideas"[146].

- The initial "referral [was] due to [Ian's] risks towards women"[147].

- Treatment plan agreed with the consultant psychiatrist was to transfer Ian's risperidone to a depot injection[148].

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[141] Diazepam -Valium- benzodiazepine is a sedative which is prescribed for its anxiety -relieving and muscle-relaxing effects. Diazepam
[142] PRN – as needed
[143] MHA assessment – Mental Health Act 1983 assessment
[144] AWP progress notes 10 December 2015 7pm
[145] AWP progress notes 12 December 2015
[146] AWP progress notes 16 December 2015 4.34pm
[147] AWP progress notes 16 November 2015 3.09pm
[148] Fortnightly into the deltoid muscle (a rounded, triangular muscle located on the uppermost part of the arm and the top of the shoulder)

- Ian was advised that he needed to go to his GP for blood tests and an electrocardiogram (ECG)[149] in preparation for this change.

- Supported housing staff reported to BCS that prior to their visit "there was some sexualised content to [Ian's] speech".[150]

- Ian reported that he had visited the GP for the physical tests that had been requested but that he would have to go to the hospital for the ECG.

6.26 23 December 2015: A BCS review took place. It was documented in Ian's progress notes that the support being provided was to monitor his mental state and his risk to others and to prevent a crisis developing. With regard to Ian's long-standing risk to others, it was also documented that the visiting team had some concerns about Ian's recent deterioration, but this has not been observed.

6.27 24 December 2015: Ian disclosed that his alcohol consumption had increased and that he had been sick. The BCS practitioner documented that Ian had been advised about the contraindications of drinking with his medication.

6.28 27 December 2015: It was documented that Ian had "wondered if he should have a bed at the [inpatient unit]"[151]. The visiting member of BCS documented that he agreed that he would discuss this with the team.

6.29 28 December 2015: A member of the support housing team reported that Ian:

"Had displayed some behaviour to staff last night that had been vaguely intimidating. He had stood next to a member of staff and made vague threats towards another resident … reported thoughts to harm another resident that he had previously assaulted but said that he would not act on these thoughts … [Ian] continues to be fairly over involved with another resident … [Ian] has recently learnt that a male resident he does not like and has assaulted has had a recent sexual relationship with his female friend."[152]

- It was also documented that Ian's mood "subjectively unsettles with some thoughts of self-harm. Mentioned stabbing himself in the chest."[153].

6.30 29 December 2015:

- Supported housing staff reported to BCS that Ian had been:

[149] ECG used to check heart's rhythm and electrical activity. ECG
[150] AWP progress notes 16 December 2015 4.34pm
[151] AWP progress notes 27 December 2015
[152] AWP progress notes 28 December 2015
[153] AWP progress notes 28 December 2015

"Quite paranoid and also made threats to smash another residents face (the same resident who [Ian] had assaulted previously). Staff also reported that Ian had made reference to purchasing a gun."[154]

- Ian reported that he was not happy that Kamil was living in the house, as he was:

  "An illegal immigrant … [Ian] reported that several months ago Kamil had made threats to stab [Ian] … [Ian] reported that he was planning to make a log of Kamil's activities in the house in an attempt to get him evicted."[155]

- Ian also made accusations about a particular male member of the supported housing staff who he reported had been acting inappropriately towards a female tenant.[156]

6.31 30 December 2015:

- The consultant psychiatrist assessed Ian and concluded that there was

  "no evidence of full delusional beliefs denied any plans to harm anyone. [Ian] had good insights and full capacity to understand what is deemed criminal activity and what the consequences would be … Did not express need for hospitalisation. Not detainable."[157]

- It was documented that Ian gave his permission for information to be shared with his brother and sister-in-law, whom he was going to spend New Year with. No Consent to Share Information form was completed, and there was no documented evidence that information was shared.

- It was also documented by the consultant psychiatrists that:

  "Clear advice given to staff that currently there [was] no evidence of relapse … any threatening behaviour will need to be followed up by the police [and Ian is] aware of this."[158]

- It was documented that there had been a change in Ian's presentation and that he was possibly exhibiting some "possible early warning signs"[159].

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[154] AWP progress notes 29 December 2015

[155] AWP progress notes 29 December 2015

[156] Sancus Solutions' investigation team were informed that this allegation was investigated and that it was concluded that there was no evidence to support Ian's accusation. Ian's support worker was then changed.

[157] AWP progress notes 30 December 2015

[158] AWP progress notes 30 December 2015

[159] AWP progress notes 8 December 2015

- During a subsequent telephone conversation, Ian reported to the recovery navigator that he was:

  "Aware of his relapse signature … denied any thoughts to harm self or others [He was] asked specifically about fellow service users and denied concerns."[160]

7 January to May 2016

7.1 3 January 2016: It was documented by a member of BCS that during their visit, Ian's presentation was:

"Calm, settled and appropriate throughout the visit … he spoke about Kamil and stated that he strongly disliked him but reiterated that he is avoiding contact with him."[161]

7.2 4 January 2016: Ian received his first depot injection – Risperdal Consta 37.5mg[162] – which was administered by his care coordinator.

7.3 8 January 2016:

- BCS discharged Ian from the service.
- Ian was reviewed by his consultant psychiatrist, who noted that there "was no evidence of [a] psychotic relapse"[163].
- The following treatment/care plan was agreed with Ian:

  – A reduction programme to reduce Ian's oral risperidone.
  – The recovery navigator would contact Ian and the supported housing team on the weeks where the care coordinator was not visiting in order to identify and monitor indications that Ian's mental health was deteriorating.

7.4 19 January 2016: At Ian's request a GP made a home visit. Ian was experiencing a painful knee, which he reported occurred when he fell while he was "intoxicated"[164].

7.5 27 January 2016: The supported housing staff manager contacted the recovery navigator, reporting that in the past few days Ian was:

[160] AWP progress notes 8 December 2015
[161] AWP progress notes 3 January 2016
[162] Risperdal Consta
[163] AWP progress notes 8 January 2016
[164] GP notes

"Over involving himself … being negative/derogatory about Kamil. The previous night he was repeatedly disrupting Kamil by buzzing Kamil's room."[165]

Kamil had reported this to supported housing staff, saying that he was "quite upset about it"[166]. It was also documented that the supported housing staff had advised Kamil to call the police if he felt threatened again[167]. They also reminded Ian that this behaviour was unacceptable and informed him that if it continued, he would be in beach of his tenancy.

Ian's care coordinator documented that "there may be an indication to increase [Ian's] depot medication as a protective factor"[168].

7.6 1 February 2016: The care coordinator administered Ian's depot injection (50mg).

7.7 17 February 2016: During a visit by the consultant psychiatrist, the service manager reported that Ian had written a letter of complaint about Kamil but had not threated to harm him. No concerns regarding Ian's mental health were documented.

7.8 29 February 2016: The care coordinator administered Ian's depot injection (50mg).

7.9 AWP's SIR noted in the 'lessons learnt' section that:

"In February 2016 a Consultant Forensic Psychiatrist attended a multi-agency meeting at the Recovery Service base to discuss [Ian's] care and treatment but there was no record of what was discussed, suggested or agreed."[169]

A liaison meeting was held to discuss Ian's risk and management. The meeting was attended by professionals from the assessment and recovery service and a forensic consultant psychiatrist. Staff from Milestones Trust reported that they were only invited to attend the latter part of the meeting. A written record of this meeting was not made.[170]

[165] AWP progress notes 27 January 2016
[166] AWP progress notes 27 January 2016
[167] This advice was documented in Milestones Trust's chronology
[168] AWP progress notes 28 January 2016 3.38pm
[169] AWP SIR p4
[170] AWP SIR p4

7.10 14 March 2016: A professional meeting involving Ian's care coordinator discussed concerns about Ian approaching a female tenant in a "sexualised way"[171]. Ian's care coordinator administered Ian's depot injection (50mg).

7.11 29 March 2016: The care coordinator administered Ian's depot injection (50mg).

7.12 30 March 2016: At the assessment and recovery team's cluster meeting, Ian was discussed:

"[There are] difficulties in maintaining Ian's supported housing placement due to antisocial behaviour … support staff have requested another professional meeting."[172]

It was agreed that the consultant psychiatrist would review Ian and that his mental state would be assessed at each contact. A clear plan (including a relapse and management plan) was to be developed, and a professional meeting was to be arranged.

7.13 31 March 2016: Ian made several accusations against Kamil and was also acting in an intimidating manner towards another tenant, whom he accused of protecting Kamil.

7.14 1 April 2016: Ian was reported to have refused Kamil entry to the service and was making racist comments. Kamil reported the incident to the police, and the service manager wrote an email to Ian's care coordinator and also Kamil's support services. Milestones Trust issued Ian with his final written warning.

7.15 5 April 2016:

- Milestones Trust raised a safeguarding alert.
- A member of the supported housing staff team contacted the duty team to report that Ian was exhibiting:

"All of his early warning signs, bizarre and paranoid thinking … He [was] obsessed with everything to do with Kamil … becoming sexually inappropriate with staff and clients … major concerns with his ongoing fixation with staff and the tenant Kamil."[173]

[171] AWP progress notes 14 March 2016
[172] AWP progress notes 30 March 2016
[173] AWP progress notes 5 April 2016

7.16 11 April 2016: As the care coordinator was on holiday, Ian was visited by another member of the team, who administered his depot injection. It was documented that Ian's presentation was "warm, pleasant and welcoming"[174].

7.17 26 April 2016: Ian refused his depot injection.

7.18 27 April 2016: Ian consented to have his depot injection. It was noted that there was "no evidence of risk to self/others"[175].

7.19 5 May 2016: Ian's care coordinator made a referral to social care for an assessment of Ian's needs and to review whether the supported housing service was able to meet Ian's needs.

7.20 6 May 2016:

- The consultant psychiatrist, the recovery navigator and a member of the supported housing staff met with Ian. It was documented that Ian was not presenting with any particular concerns and there was no evidence of psychosis.

- Ian reported that he was aware he was on his final written warning and that he knew what he had to do in order to remain at the service. Ian also reported that he had no thoughts to harm himself or others.

- The consultant psychiatrist advised the supported housing staff that they should call the police if they had any further concerns about Ian's behaviour.

- A letter outlining the assessment and concerns was sent to Ian's GP.

7.21 13 May 2016: The care coordinator administered Ian's depot injection.

7.22 24 May 2016: The support worker recorded that Ian had stated that he "did not care if he spent the rest of his life in prison"[176].

7.23 27 May 2016: Ian's depot injection was administered.

8 June to 6 July 2016

8.1 6 June 2016:

- A member of the supported housing team reported to Ian's care coordinator that the CCTV at the service showed that Ian was sleeping in the hallway and was observed reacting to auditory hallucinations. Ian was also observed

[174] AWP progress notes 11 April 2016
[175] AWP progress notes 27 April 2016
[176] AWP progress notes 24 May 2016

masturbating in front of another tenant and had disclosed that he had sex with a female tenant.

- A safeguarding alert was actioned by the supported housing staff with regard to Ian's report that he had sex with a vulnerable female tenant.

- A member of the supported housing staff advised the care coordinator that they had consulted with UCHA, who had informed them that they could seek an eviction but that more evidence would be required to support this course of action.[177]

8.2 8 June 2016: Ian was discussed at the assessment and recovery service's cluster meeting. It was suggested that Ian:

"Appears to have capacity … he attributes the behaviour to being psychotic which in turn may well be linked to using skunk."[178]

It was agreed that the consultant psychiatrist would review Ian, and the supported housing staff were to be advised to involve the police.

- During a subsequent telephone call with the consultant psychiatrist, Ian disclosed that he had recently smoked skunk.

- It was assessed that Ian had:

"Full capacity to understand [the] implications of drug and alcohol misuse on his behaviour and that some of his behaviour was entirely inappropriate."[179]

- Ian agreed to be prescribed Quetiapine[180] 50mg nocte, as "this has helped with his sleep in the past"[181].

- 7.45pm: The duty team received a telephone call from Ian in which he sounded intoxicated and was sexually inappropriate throughout the call.

- 9.45pm: BCS received a telephone call from Ian. It was documented that he was sexually inappropriate and disclosed that he had been smoking skunk.[182]

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[177] Ian was on an assured tenancy. Unlike a short assured tenancy, with an assured tenancy agreement landlords must wait until particular limited circumstances have occurred that give them grounds to seek a possession order against the tenants (such as the tenants being in rent arrears). Assured Tenancy

[178] AWP progress notes 8 June 2016

[179] AWP progress notes 8 June 2016

[180] Quetiapine is an atypical antipsychotic drug used to treat certain mental/mood conditions (such as schizophrenia, bipolar disorder and sudden episodes of mania or depression associated with bipolar disorder). Quetiapine

[181] AWP progress notes 8 June 2016

[182] AWP progress notes 8 June 2016

8.3 9 June 2016:

- Care coordinator visited Ian. A member of the supported housing staff reported that Ian was "wide eyed and at times bizarre" [183].However, it was documented that Ian was presenting "clear and coherent in [his] speech"[184].

- Depot was administered.

- It was documented that Ian initially declined a hospital admission but later phoned the care coordinator and agreed to be admitted. He was placed on the inpatient waiting list.

8.4 10 June 2016:

- Supported housing scheme staff reported that they had found over 30 threatening notes written by Ian under the office door. The contents of the notes included delusional ideation, comments on his current state of mind, graphic sexual references, references to the mental illness of other tenants, and threats to kill particular tenants, including Kamil, and members of the public.

- The supported housing staff reported to the police the contents of the notes and the CCTV footage.

- The supported housing staff also reported their concerns about Ian to his recovery worker, who visited Ian with a member of BCS.

- Ian accepted his depot injection.

- As no inpatient bed was available, a care plan was agreed whereby Ian would receive BCS support over the weekend.

- A safeguarding alert was made by the supported housing service.

- The consultant psychiatrist advised BCS to contact the police, as Ian was making threats to harm others, and stated that the police should consider the use of a "Section 136[185] if Ian was located in a public place"[186].

- 5.04pm: Two members of BCS visited Ian. Prior to meeting him, they discussed the current situation and Ian's recent history. It was assessed that

[183] AWP progress notes 9 June 2016

[184] AWP progress notes 9 June 2016 1.45pm

[185] Section 136 is an emergency power which allows a person to be taken to a place of safety from a public place, if a police officer considers that they are suffering from mental illness and in need of immediate care. Section 136

[186] AWP progress notes 10 June 2016

Ian's "risk to others appears currently high, due to [a] high level of risk and fluctuating capacity"[187]. He was prescribed diazepam.[188]

- A Mental Health Act 1983 assessment was requested. The EDT responded that they would not undertake the Mental Health Act 1983 assessment until a suitable inpatient bed had been located.

- 10.48pm: BCS were informed that there was a bed available on an open ward at the local Cygnet Health Care hospital. A further request was made for a Mental Health Act 1983 assessment to be completed.

8.5 11 June 2016:

- 2.36pm: BCS contacted the AWP bed management team to request a bed on the psychiatric intensive care unit (PICU). The local Cygnet Health Care hospital was contacted and reported that if Ian was assessed as being suitable for their open ward, they would accept him.

- A referral was sent to both Cygnet Health Care[189] and Blackheath hospitals.[190]

- Subsequently, Cygnet Health Care reported that they were unable to accept the referral, as they had no AWP beds available. Blackheath hospital also reported that they were unable to accept the referral, as they were unable, at that time, to manage Ian's risk.

- 2.51pm: The EDT Approved Mental Health Practitioner[191] (hereafter referred to as AMP) reported that as there were no inpatient beds available, they would not undertake the assessment. The AMP advised BCS to contact the police if Ian presented with further risks to others and agreed that they would send a referral to St Andrew's[192] hospital.

- 3.36pm: A member of BCS contacted AWP's bed management team to discuss the possibility of stepping down a number of AWP patients to Cygnet Health Care's open ward in order to free a bed on the PICU unit. The urgency

[187] AWP progress notes 10 June 2016 5.04pm

[188] Diazepam belongs to a group of medicines called benzodiazepines. Diazepam

[189] Cygnet Health Care had a contract with AWP that secures a number of beds for AWP patients. This contract will be discussed in further detail later in the report.

[190] Blackheath Hospital is a private hospital in London run by BMI Healthcare

[191] AMHPs are mental health professionals who have been approved by a local social services authority to carry out certain duties under the Mental Health Act 1983. They are responsible for coordinating Mental Health Act 1983 assessments and admissions to hospital.

[192] St Andrew's Healthcare is a large independent charity based at St Andrew's Hospital in Northampton, which provides psychiatric services

of the situation was discussed, including the fact that Ian had been assessed as being at "HIGH risk in the community over the weekend"[193].

- 8.08pm: BCS were informed that the Mental Health Act 1983 assessment would not take place until the following day due to capacity issues within the EDT. BCS were also informed that an AWP bed on the PICU would be available so that the assessment could take place the following day.

8.6 12 June 2016:

- 7.04am: BCS contacted the PICU unit to inform them that Ian's assessment would take place at 11am.

- 2.47pm: EDT informed BCS that they had been unable to undertake the assessment, as Ian was not at his accommodation. The AMP also reported that:

  "Prior to doing the assessment [the AMP] had noted that [Ian] had been delivered some medication yesterday by BCS … In light of learning about [Ian] accepting the delivery of medication she [was] not going out to reassess. She asked that BCS go out to reassess whether [Ian] needed a MHA assessment."[194]

  She also suggested that Ian be re-referred the following day. A BCS worker documented that she challenged this decision and

  "pointed out that [Ian] had clearly stated that he won't take the medication and questioned whether an increase of 100mg quetiapine would resolve [Ian's] current mental state, high levels of risk and gross sexual disinhibition"[195].

- BCS's worker then documented that she had escalated her concerns to the EDT's manager, who it was documented agreed with the decision the AMP had made. A member of BCS submitted an incident report outlining concerns relating to EDT's actions and decisions.

- 5.30pm: Members of BCS visited Ian, but there was no response.

8.7 13 June 2016:

- 9.39am: Telephone contact was made with Ian, who reported that he would be in all day. BCS again requested that EDT arrange for a Mental Health Act 1983 assessment.

[193] AWP progress notes 11 June 2016 3.36pm
[194] AWP progress notes 12 June 2016 2.47pm
[195] AWP progress notes 12 June 2016 2.47pm

- 12.38pm: Police attended the supported housing services and, after viewing the CCTV footage of Ian exposing himself and other sexual behaviours, arrested Ian.

- A Mental Health Act 1983 assessment was undertaken while Ian was in police custody.

- 8.51pm: Ian was detained under Section 2 of the Mental Health Act 1983 and transferred to AWP's PICU ward.

- Supported housing staff made a safeguarding referral with regard to the safety of the female tenants.

AWP inpatient admission

8.8 13 June 2016: Following Ian's admission to the unit:

- A comprehensive mental health state examination and a physical health assessment were completed. This included a very brief outline of Ian's forensic history.

- It was documented that Ian had Asperger's[196]. The assessment also documented that Ian had previously been on Clozapine" but had to stop it 2 years ago due to a low blood count"[197].

- During this admission, it was being documented that although Ian was, at times, making some sexualised and grandiose comments to the ward staff, there were no other particular concerns. He was engaging with the ward routine and was participating, to a degree, with ward activities such as art and music therapy.

- 14 June 2016: At the initial ward round, a treatment plan was agreed. This included continuing with Ian's medication regime, and the nursing staff were to make standard hourly observations and monitor any possible risks.

- The supported housing staff telephoned Ian's care coordinator to request a meeting to discuss the future of Ian's placement. The care coordinator confirmed that the supported housing staff would be invited to the next CPA meeting, although the date for this review had not yet been agreed. The care coordinator was also informed that in light of the recent events, the concerns

[196] Asperger's is a developmental disorder characterised by significant difficulties in social interaction and non-verbal communication, along with restricted and repetitive patterns of behaviour and interests.
[197] AWP progress notes 14 June 2016

regarding the safety of the other tenants and the fact that Ian had been given a final warning, it was the intention to serve Ian with his Notice to Quit.[198]

8.9 15 June 2016:

- The police contacted the ward to ascertain where Ian was an inpatient.
- The AMP who was involved in the Mental Health Act 1983 assessment emailed the ward, reporting that the assessment team:

  "Were concerned about [Ian's] reference to 14-year-old girls and paedophilia as was the custody sergeant who on discussion referred this matter up to their investigation team. … The assessing team were concerned about [Ian's] potential risk to children and young women and would advise that a full risk assessment is undertaken [in] respect of these risks."[199]

- It was also reported in the email that when Ian was disclosing this, it was "in connection to a massage parlour"[200].

8.10 16 June 2016:

- The supported housing staff received a telephone call from the police.
- Risk summary point in time was completed by a member of the inpatient unit nursing staff.

8.11 20 June 2016: The bed management team decided that Ian was to be transferred to Cygnet Health Care's PICU. It was documented that the ward was "questioning why Ian was being transferred from one PICU unit to another"[201].

8.12 A discharge summary was sent with Ian to Cygnet Health Care's hospital, and a copy was also faxed to Ian's GP.[202]

8.13 23 June 2016:

- Following a visit by the police to AWP's PICU ward, a member of the ward staff sent an email to the police, reporting that they:

  "Were of the opinion that [Ian] understood the meaning and consequences of his actions related to index incidents and had capacity into the nature of his actions although the [recent] occurrence may have been contributed [to] due

[198] Information documented in Milestones Trust's chronology but not in AWP's patient records
[199] AWP progress notes 15 June 2016
[200] AWP progress notes 15 June 2016
[201] AWP progress notes 20 June 2016
[202] There was no indication that the supported housing staff were informed of the transfer

to deterioration [in his] mental health along with excessive substance and alcohol misuse"[203].

- The email did not inform the police that Ian had been transferred to the Cygnet Health Care PICU.

Cygnet Health Care's inpatient admission

8.14 On admission, Ian was initially placed on 15-minute observations.

8.15 A Short-Term Assessment of Risk and Treatability (START)[204] assessment and risk formation and a Brief Psychiatric Rating Scale (BPRS)[205] were completed.

8.16 Ian's responsible clinician (hereafter referred to as RC)[206] was transferred to Cygnet Health Care's inpatient consultant psychiatrist. Ian was issued with Mental Health Act 1983 information, which included information about the right to appeal against his section.

8.17 20-21 June 2016:

- A multi-disciplinary care plan was completed.
- A Patient Consent to Share Information form was completed, which identified that Ian had consented for information to be shared with his brother.

8.18 22 June 2016: The AWP inpatient unit telephoned the Cygnet Health Care PICU ward to obtain an update on Ian.[207]

8.19 23 June 2016:

- It was documented that the plan was to "refer him back to [the] open acute ward in Bristol"[208].

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[203] AWP progress notes 23 June 2016

[204] START (Short-Term Assessment of Risk and Treatability) is a concise, clinical guide to the assessment of short-term risk for violence and treatability. The START is a concise clinical guide for the dynamic assessment of short-term (i.e. weeks to months) risk for violence (to self and others) and treatability. START

[205] The Brief Psychiatric Rating Scale (BPRS) is a rating scale which a clinician or researcher may use to measure psychiatric symptoms such as depression, anxiety, hallucinations and unusual behaviour. Each symptom is rated 1-7, and, depending on the version, a total of between 18 and 24 symptoms are scored. The scale is one of the oldest, most widely used scales to measure psychotic symptoms and was first published in 1962. BPRS

[206] The Responsible Clinician (RC) has overall responsibility for care and treatment for service users being assessed and treated under the Mental Health Act 1983. These responsibilities include making decisions about treatment, reviewing detentions, assessing whether the criteria for renewing detention are met and granting leave of absence for detained patients. Responsible clinician (RC)

[207] Cygnet Health Care continuous written records 23 June 2016

[208] Cygnet Health Care continuous written records 23 June 2016

- It was documented that the reason why he had been transferred from "PICU to PICU [was] not established"[209].

- Ian reported to the ward staff that he had applied for a First Tier Tribunal[210].

8.20 24 June 2016: The RC completed his report for the Mental Health Tribunal.

8.21 26 June 2016: Ian began to be granted escorted Section 17 leave[211] in the hospital grounds. One Section 17 leave risk assessment was completed.

8.22 27 June 2016:

- Ian's level of observation was reduced to hourly observations.

- AWP's SI report documented that Ian's care coordinator was notified that a Mental Health Tribunal was to be convened.[212] This was not documented in AWP's notes.

- Cygnet Health Care's continuous written records documented that they received a phone call from the care coordinator "enquiring about [Ian] to complete his MHRT[213] report"[214].

- A Social Circumstances Report[215] (SCR) was completed by the care coordinator.[216]

- Milestone Trust received a telephone call from Ian's care coordinator requesting information to inform his Mental Health Tribunal Report and to ascertain status of his tenancy.

8.23 28 June 2016: The First Tier Mental Health Tribunal took place.

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[209] Cygnet Health Care continuous written records 23 June 2016

[210] A patient can apply for a First Tier Mental Health Tribunal hearing within 14 days of being detained under a Section 2 of the Mental Health Act 1983. First Tier Mental Health

[211] Section 17 of the Mental Health Act (1983) allows the Responsible Clinician (RC) to grant a detained patient leave of absence from hospital. It is the only legal means by which a detained patient may leave an inpatient unit. Section 17

[212] AWP's SIR p42

[213] MHRT: Mental Health Review Tribunal

[214] Cygnet Health Care continuous written records 26 June 2016 9.15am

[215] The main purpose of an SCR is to provide the tribunal with 'hard' evidence of the patient's circumstances if discharged from hospital, in particular, what medical, social services and other support will be available in the community, together with 'soft' – but also potentially significant – evidence about the views of the nearest relative and non-professional others who play a significant part in the patient's care, the patient's own views, and an assessment of the patient's strengths and positive factors. The SCR should provide evidence of planned aftercare, in line with the guidance in the MHA Codes of Practice for England and Wales on the duty to provide aftercare under MHA 1983 s117 and the English and Welsh policy guidance on the Care Programme Approach (CPA). SCR

[216] At the beginning of the report, the date of completion was given as 23 June 2016

- A pre-hearing examination meeting with Ian was conducted by the medical member of the Mental Health Tribunal Panel.

- Cygnet Health Care's continuous written records stated that "a discharge meeting has to be put in place to discuss and make a thorough plan for [Ian] to be discharged safely back to the community"[217].

- An entry in AWP's patient records by Ian's care coordinator documented the decision made by the Mental Health Tribunal and stated also that a

  "CPA will be needed as a priority, preferably when [Ian] returns to Bristol"[218].

- The decision reached by the Mental Health Tribunal was that it was

  "Not satisfied that [Ian] was suffering a mental disorder of a nature or degree which warranted his continued detention"[219].

  The panel agreed that Ian's discharge from the section would be deferred until 6 July 2016 in order to allow time for discharge planning to take place.

8.24 29 June 2016:

- Ian was transferred to an acute open ward.

- A member of the nursing staff documented that Ian's brother:

  "Was surprised by the tribunal decision, is concerned about him being discharged due to his recent presentation and would like his medication reviewed. Brother reported that clozapine was the most effective medication he had been on to date but understands that due to his physical health complications this was stopped."[220]

- A second START risk assessment was completed.

- At a liaison meeting, Milestones Trust advised UCHA that Ian had been taken to hospital and was sectioned. They asked UCHA to issue a Notice to Quit with the aim of ending Ian's tenancy. United Communities advised:

  "To service a Section 21 notice as this was more legally binding. The process would be a 2 month notice and then a court hearing to follow after 6 weeks of the expiry of the notice if [Ian] had not left the home. United Communities

[217] Cygnet Health Care continuous written records 28 June 2016
[218] AWP progress notes 28 June 2016
[219] Cygnet Health Care continuous written records 28 June 2016
[220] Cygnet Health Care continuous written records 29 June 2016

asked for all information from Milestones Trust in relation to this. This included incident logs and notes."[221]

8.25 30 June 2016:

- Ian was a victim of an unprovoked physical attack by another patient. Ian was interviewed by the police and stated that he wished to press charges.

- A care plan was completed.

9 Events on the day of Ian's discharge

9.1 6 July 2016:

- 6.10am: Night staff documented that Ian had approached them and stated: "I have never punched a woman … I have punched a man."[222]

- At an AWP multi-disciplinary team meeting, it was documented that Ian:

  "Stated his accommodation had given him notice but he [was] being referred to the Maples as another option … [Ian] stated that he wouldn't stay informally until accommodation was found for him. He spoke about his social worker finding him somewhere before he is discharged… all risks were low."[223]

- The following discussion was had by the care coordinator and AWP's acute pathway lead:

  "Given the risk/safeguarding issues that led up to the admission [a] comprehensive discharge planning will be essential. It is likely that Milestone[s] will end [Ian's] tenancy for this reason and discussions will need to take place with the provider who will update me tomorrow re status of [Ian's] tenancy."[225]

- 9.21am: A member of AWP's bed management team documented that Ian was:

  "Likely to be made informal at 4 pm tomorrow afternoon (Wednesday) … [Ian] has made it clear that he will be looking to discharge himself."[226]

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[221] UCHA's report for SAR p4
[222] Cygnet Health Care continuous written records 6 July 2016 6.10am
[223] Cygnet Health Care multidisciplinary team meeting 5 July 2016 p4 [224]
Cygnet Health Care risk assessment 5 July 2016
[225] AWP progress notes 5 July 2017
[226] AWP progress notes 5 July 2017

- 10.20am: An inpatient nurse left a message requesting that a member of AWP's recovery team contact them to discuss Ian's discharge plan.

- 11.25am: At a Green Cluster Meeting[227], Ian's care coordinator outlined the current situation regarding Ian's imminent discharge. Actions agreed were to:

  "Liaise urgently with the [supported housing scheme] and checking tenancy discharge planning needs to be done urgently. Social Services have lost the original referral and so this needs to be done today and needs to request it be given priority."[228]

- 12.16pm: UCHA emailed Ian's care coordinator to advise that they were serving Ian with a Section 21 Notice to end the tenancy.

- 12.50pm: Ian's care coordinator contacted a member of the supported housing service staff to inform them that Ian's section "was being lifted"[229]. The staff member informed the care coordinator that he:

  "did not think this was a good idea but [the care coordinator] said there was nothing he could do further"[230].

- 1.05pm approximately: UCHA received a phone call from Milestones Trust for the lead worker, who was not available. No message was left.
- 1.09pm: The care coordinator contacted the Milestones Trust's project coordinator to confirm that Ian's section was going to be lifted at 4pm and that he was intending to return to the scheme.

- 2.24pm: An email was sent to the care coordinator from Milestones Trust's project coordinator informing him of what actions they intended to take to prevent Ian returning to the service.

- - 2.58pm approximately: UCHA were contacted again by Milestones Trust, who wanted to speak to the Head of Housing. He was not available.3.05pm: UCHA's lead worker contacted Milestones Trust and was informed that Ian was being discharged from hospital.

- 3.32pm: An entry was made by the care coordinator, documenting that Cygnet Health Care's charge nurse had informed him that Ian intended to return to the supported housing scheme that night, as he was:

[227] Green Cluster Meeting recovery team meeting

[228] AWP progress notes 6 July 2016 11.25am

[229] Milestones Trust's chronology noted that this was the first time they were aware that Ian's section was to be lifted that day

[230] Milestones Trust's chronology prepared for the SAR p27

"Unwilling to remain in hospital for his CPA. There are insufficient grounds to hold him as he [was] not exhibiting much in the way of psychotic symptoms or risk to others notwithstanding the recent safeguarding issues."[231]

- The agreed plan was that the social care referral would be re-sent and a care planning meeting would be convened.

- BCS accepted a referral to provide support, to manage his risk and also to support the staff at the supported housing scheme.

- 3.30pm: Ian's care coordinator contacted the ward "initially requesting that [Ian] remained in hospital until a sufficient discharge plan is in place"[232]. The care coordinator was informed that Ian had refused to remain as an informal patient and that his presentation did not meet the threshold of a Mental Health Act 1983 assessment. Ian had arranged for his brother to collect him at 4pm when his section was discharged.

- It was also documented that the inpatient staff member had discussed Ian with the ward manager, who agreed that they "had no rationale"[233] to further detain Ian. It was also documented that the care coordinator reported that eviction procedures had been instigated but that this would take a month to complete. A Discharge Against Medical Advice Form was completed and sent to Ian's GP and AWP.

- 3.32pm: An entry was made by UCHA's Acting Tenancy Sustainment Manager, reporting that the supported housing manager had been in contact to report that Ian had been discharged and that they intended to pursue a Without Notice Injunction[234] as well as a Section 21 Notice[235] to prevent Ian from returning to the service.

- 4.33pm: An entry was made by the care coordinator, documenting that he had a discussion with the supported housing manager, who had reported that:

  "Nothing will happen tonight and to follow up as a priority with social services. [Ian] may have to go into temporary accommodation."[236]

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[231] AWP progress notes 6 July 2016 3.52pm

[232] Cygnet Health Care continuous written records 6 July 2016 3.30pm

[233] Cygnet Health Care continuous written records 6 July 2016 3.30pm

[234] A 'without notice' application is made without the other party having any notice of the application or being present at the application hearing. The Court will only grant an injunction on such an application if there are good reasons for not giving the respondent any notice (e.g. the matter is so urgent that the applicant does not have time to tell the respondent that he intends to seek an injunction, or where giving notice would lead to a serious risk of evidence being destroyed or assets being dissipated before the injunction is heard. Without Notice Injunction

[235] Section 21 notice: if a tenant has an assured shorthold tenancy, a landlord does not have to give any reason for asking a tenant to leave their property Section 21

[236] No further entries w ere documented in AWP's patient records until 1.48am n 7 July 2016, when Ian made telephone contact with AWP's crisis line (refer to the description of events leading up to the incident)

- 4.36pm: UCHA's lead worker rang and emailed Ian's care coordinator, stating that Ian should be advised not to return to the property and that they intended to issue a Without Notice Injunction.4.50pm: UCHA's lead worker rang Milestones Trust and asked for a report to support the injunction against Ian and to advise that an injunction was unlikely to be obtained due to time; however, it was their intention to apply on the following day. UCHA's lead worker also sent a letter to the police, asking for a full disclosure of any actions/incidents related to Ian.4.59pm: Milestones Trust's project coordinator contacted BCS and was informed that they were not intending to visit Ian that day but would contact the services the following day to arrange a meeting. The service manager informed BCS that she intended to raise a safeguarding alert.

- 5.32pm: UCHA's lead worker contacted their solicitor to discuss a Notice and Injunction to prevent Ian from returning to the property.

- 7.47pm: Milestones Trust's project coordinator emailed the safeguarding referral. She sent copies to UCHA and Milestones' Area and Head of Operations.

- 10.30pm: UCHA received a report, by email, from Milestones Trust to support the request for an injunction. It was also documented that the other tenants had been made aware of Ian's return to the property.[237]

See section 1 for a detailed summary of events from the time that Ian was discharged from Cygnet Health Care's inpatient unit, up to the incident on 7 June 2016.

Section 3

This section will address the following NHS England terms of reference: "Review

the quality of assessment and treatment plans that were provided by all NHS provider organisations and including, non-NHS organisations identified in the level 2 investigations from August 2015.

Review the effectiveness of communication, information sharing and decision making between agencies and services, including the Housing Provider, local Police and Adult Safeguarding Services."[238]

[237] It is unclear if Kamil was informed

[238] NHS England Terms of Reference p1

10 Recovery navigator

"Review the rationale for the allocation of a Band 4 worker from the AWP Recovery Service, to an individual with an extensive and complex psychiatric/forensic history and comment as to whether that was appropriate."[239]

Sancus Solutions' report has addressed this particular TOR first because the role of recovery navigator within the assessment and recovery team is central to an understanding of Ian's care and treatment from 2015.

10.1 Ian's recovery navigator was recruited by a third sector women's mental health and housing agency on the grade that is equivalent to an NHS band 4. She reported that her induction training was provided by another third sector supported housing agency. Following her induction training, she was placed within AWP's assessment and recovery service.

10.2 Ian's recovery navigator initially began supporting him alongside the care coordinator from 5 March 2015. By July 2015 the care coordinator had reduced his involvement to monthly visits to dispense Ian's depot injection.

10.3 By 30 March 2015 the recovery navigator had reviewed Ian's risk assessment, crisis plan and core assessment overview. She then reviewed his core assessment overview and crisis plan again on 27 May 2015. On 13 November 2015, the recovery navigator reviewed Ian's care plan. This was the only crisis plan that was completed in this format.

10.4 The recovery navigator's role was to provide support, coordinate Ian's blood tests and deliver his clozapine medication.

10.5 There was considerable evidence that when Ian became unwell (from November 2015 to June 2016), the recovery navigator was regularly liaising with the staff from the supported housing scheme and was visiting Ian with both the assessment and recovery service's community consultant psychiatrist and members of the BCS team.

10.6 The recovery navigator reported that she attended the weekly multi-disciplinary team (MDT) meeting and the team's daily cluster meetings when Ian was being discussed.

[239] NHS England Terms of Reference p1

Commentary and analysis

Bristol Mental Health

10.7 In order to comment on the allocation and role of Ian's recovery navigator, it is necessary to have an understanding of the provision of mental health services within Bristol:

- In October 2014 a partnership, involving AWP and a number of third sector agencies, successfully tendered to provide mental health services within the city of Bristol. This service is now known as Bristol Mental Health.[240] There are 18 partner agencies, which provide a variety of community mental health, housing, crisis, support and advocacy services. AWP provides the adult mental health inpatient services.

- Milestones Trust is not one of the partner agencies.

10.8 The underpinning ethos of the partnership is to "strive to achieve the best mental health and wellbeing for all the people of Bristol"[241].

10.9 The aim of Bristol Mental Health is to provide "integrated and responsive services from the point of the patient's initial contact/referral"[242].

10.10 One of the innovative developments introduced by Bristol Mental Health was the recruitment of recovery navigators, whose role is to:

> "Promote people's independence, health and general recovery … Their focus [is] on coordinating and accessing the best possible support for each client to help them manage their mental health problems – and to ensure that recovery takes place in the best way for them … Work with service users to give support, advice and to help plan their recovery with them throughout their journey. Recovery can mean different things to different people … living a meaningful life with or without symptoms of mental ill health. The recovery navigators are there to help prioritise what is important and help [a person] to set and work towards [their] own goals."[243]

Recruitment and training

10.11 Although recovery navigators can be situated within statutory services, such as AWP's assessment and recovery service, they are recruited and employed by a number of third sector organisations, such as adult mental health support housing services and women's mental health services.

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240 Bristol Mental Health
241 Bristol Mental Health
242 Bristol Mental Health
243 Assessment and recovery service

10.12 The recovery navigators receive initial induction training from the recruiting third sector agency, whose ongoing involvement is to provide human resources services, such as payroll. Recovery navigators meet with their employing agency on a quarterly basis.

10.13 Ian's recovery navigator reported that since she' was recruited, over three years she has received one day of risk and care planning training, which was provided by AWP, although the team do have continued professional development (CPD) sessions, where risk has been discussed.

AWP's assessment and recovery service

10.14 It was reported that a number of roles are undertaken by the recovery navigators located within AWP's assessment and recovery service. These include:

- Providing additional support to patients on a Care Programme Approach (CPA)[244].

- If a patient on a CPA is considered to be stable and at the lower end of risk(s), they can be "stepped down"[245], and their ongoing support is then provided by a recovery navigator. In such cases, the care coordinator should still maintain the overall responsibility for the patient, such as arranging CPA reviews and undertaking risk reviews.

- Where it has been assessed that a non-CPA patient meets the threshold for community mental health services and their risks and support needs are at the lower level of complexities, they are allocated a recovery navigator, who will provide ongoing support.

- The aim of a recovery navigator is to provide time-limited recovery-focused support with agreed, identified support goals and, where appropriate, to support a patient towards a managed discharge from AWP's community service once their agreed recovery goals have been reached. This does not necessarily involve withdrawing all support but can include signposting a patient to other support services.

- If a patient being supported by a recovery navigator begins to exhibit signs of a mental health relapse and/or their risk factors have been assessed as increasing, they are "stepped up"[246] to one of the more senior practitioners within the team, who will assume the care coordinating role.

[244] The Care Programme Approach (CPA) was introduced in England in 1991 as a form of case management to improve community care for people with severe mental illness. CPA

[245] Step down – when a service user requires a lower level or no intervention from AWP

[246] Step up – when a service user requires a higher level of intervention from AWP

10.15 It was reported that the recovery navigators are encouraged to utilise basic low-level CBT-skills and interventions, such as coping strategies and relaxation skills, in their support of patients.[247]

10.16 The recovery navigator who was supporting Ian reported that she attends the assessment and recovery team's weekly multi-disciplinary team (MDT) meetings.[248] When one of her patients is known to be in crisis or experiencing increased risks factors, she will also attend the daily cluster meeting, where decisions are made regarding possibly increasing the team's involvement, involving BCS or actioning a Mental Health Act 1983 assessment referral. She reported that she had attended a cluster meeting prior to Ian's last admission to the inpatient unit.

10.17 The investigation team were informed that a full-time recovery navigator within the AWP's assessment and recovery service can carry up to 30 patient cases.

10.18 The recovery navigator reported that although some risk assessments are reviewed in her clinical supervision, due to the number of patients that she is supporting it is not feasible to review all risk assessments on a regular basis. However, she believed that the team manager undertakes random audits of risk assessments within the service.

Commentary and analysis

10.19 There was considerable evidence that the recovery navigator was not only providing support to Ian but also ensuring that she was liaising with both the supported housing staff and the consultant psychiatrist.

10.20 The investigation team concluded that once Ian's clozapine had to be stopped (November 2015), given his known mental health and forensic history, in addition to his escalating risk factors, a senior practitioner within the assessment and recovery team should have assumed the role of care coordination, including having responsibility for reviewing his risk assessments and care plans (this will be discussed further in the following section).

10.21 A CQC inspection of AWP's assessment and recovery service in 2015[249] concluded that:

> "Recovery Navigators were supporting complex people. Recovery navigators often had no experience of working within the NHS and didn't understand how to work with such complex patients. There was 30% turnover of recovery

[247] Recovery Navigators receive training on therapeutic interventions

[248] MDT meetings are organised around GP localities

[249] CQC Inspection Report December 2015 CQC report 2015

navigators which meant some people had not had a consistent worker … Bristol community assessment and recovery services were not safe."[250]

10.22 However, the next CQC inspection report (February 2016) concluded that:

"The trust had put a good system in place to support recovery navigators."[251]

10.23 A review of Bristol Mental Health's current recovery navigators' recruitment programme undertaken by the investigation team noted that although there is an expectation that the applicant has some mental health experience, the role does not require a professional mental health qualification – for example a mental health nurse. The investigation team suggest that although recruiting applicants with diverse experiences to recovery navigator posts clearly has advantages, their potential lack of a mental health qualification means that they are likely not to have the required skills in areas such as undertaking complex risk assessments without clinical involvement, therefore will require intensive and on-going training and clinical supervision.

10.24 It is not clear if the last CQC inspection reviewed the training being provided to recovery navigators. The recovery navigator who was interviewed as part of this investigation reported that she had only received one day of risk training since she commenced her employment with AWP. The investigation team would suggest that this amount of training is not adequate and needs to be addressed as a matter of urgency to ensure that a comprehensive induction and ongoing risk training programme is provided to recovery navigators who are expected to undertake risk assessments.

10.25 The following section of this report addresses the fact that the risk assessments undertaken by the recovery navigator from November 2015 to Ian's admission to AWP's inpatient unit (June 2015) were not adequate and also were non-compliant with AWP's CPA and risk policies. However, what is concerning to the investigation team is that neither the recovery navigator's supervisor nor the team manager identified these deficits, either in supervision or during the audits that were reportedly taking place.

10.26 To ensure that such a deficit does not occur in the future, the investigation team have made a specific recommendation that AWP introduces a quality assurance process that provides ongoing monitoring of all risk assessments and risk management plans that are being completed by the recovery navigator within the assessment and recovery teams.

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[250] CQC Inspection Report December 2015 CQC report 2015
[251] CQC Inspection Report October 2016 CQC report 2016

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)

Recommendation 1: AWP should review the recovery navigators' induction and ongoing risk assessment training programme to ensure that they have a skill base that is commensurate with the expectations of the role.

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)

Recommendation 2: AWP should introduce a quality assurance process that provides ongoing monitoring of risk assessments and risk management plans that are being completed by the recovery navigators within their assessment and recovery teams.

10.27 In conclusion, the investigation team have reviewed "the rationale for the allocation of a Band 4 worker from the AWP Recovery Service to an individual with an extensive and complex psychiatric/forensic history"[252] and have concluded that the recovery worker provided the proportionate level of support to Ian when his mental health was stable. However, at the point when Ian's clozapine was stopped and given that it was know that this historically triggered a significant escalation in Ian's risks, the management of this patient should have been transferred to a more experienced qualified practitioner with the team.

10.28 It was noticeable to the investigation team that neither AWP's SIR nor the SAR identified or considered the role and responsibilities of the recovery navigator. The recovery navigator reported that she had not been invited to contribute to either investigation or the learning events that took place. This, the investigation team would suggest, was a significant oversight, as not only did she have a significant role in the support and assessments of Ian, but the learning from both investigations would have contributed to her professional development.

11 AWP's risk management

"Review the risk assessment and risk management plans in place at the time of the incident, with particular reference to risks posed to the victim, and other vulnerable adults and whether they were appropriately shared and understood by all agencies involved in the care and treatment of [Ian]. … Review the appropriateness of the decision-making processes and outcomes with specific reference to the transfer between inpatient services.

[252] NHS England Terms of Reference p1

Review the appropriateness of the decision-making processes and outcomes with specific reference to the transfer between inpatient services."[253]

In addition to covering the above, the following sections also provide comments on the following:

"Review the effectiveness of communication, information sharing and decision making between agencies and services, including the Housing Provider, local Police and Adult Safeguarding Services."[254]

11.1 26 June 2012: A risk summary was completed. It was assessed that both Ian's risk of harm to others and his overall risk rating were low – "no significant current risks"[255]. This assessment had brief details of Ian's forensic history from 1978 to 1991.

11.2 5 March 2013: Ian's care plan was reviewed, and the following crisis plan was identified:

- To contact the assessment and recovery team's consultant psychiatrist and out-of-hours service.
- Relapse indicators/warning signs: Ian reported that when he became unwell, he experienced "bizarre and heavy thoughts … [He becomes] paranoid about the Mafia and MI 5."[256]
- Contingency plan: Ian to seek support from the supported housing team. If there were concerns about Ian's mental health, the assessment and recovery team should be contacted.

11.3 The care coordinator and a health care practitioner (HCP) were present at this review, but there was no documented evidence that staff from Milestones Trust were present or had been asked to contribute. However, it was documented that Ian's GP "provided input"[257].

11.4 The 'consent to share information with non-healthcare professionals and client's comments about information sharing' section was not completed.

11.5 14 October 2013: Ian's risk summary was reviewed. It documented the same forensic history as the previous summary. It also documented that:

[253] NHS England Terms of Reference p1
[254] NHS England Terms of Reference p1
[255] Risk summary p1 AWP's definitions of risk ratings
[256] 5 March 2013 Care Plan updated p3
[257] 5 March 2013 Care Plan updated p3

- Two weeks after an abrupt cessation of clozapine, Ian had "got into an altercation"[258] with Kamil after he had cut the TV wire. It was documented that Ian had:

  "Apparently hit or punched [Kamil] and that [Ian's] version [was] that he acted in self-defence … He tried to shake hands in a reparation effort a few days later but the other person ignored him."[259]

- After the discontinuation of clozapine, Ian's behaviour had quickly deteriorated, and "in the past alcohol misuse [had] been closely related to [Ian's] offending behaviour and ill mental health. Past risk has been towards family and mainly staff. In the past he [had] exhibited poor impulse control outside the context of mental illness."[260]

- Ian's risk of harm to others appeared[261] to have been assessed as low, and his overall risk was assessed as medium: "current indicators of risk are present but the risk outcome is unlikely to occur unless additional risk factors intervene"[262].

- Ian's next risk summary –point in time review was scheduled for 7 October 2014, but it was reviewed on 10 December 2013[263], which was prior to his detention under the Mental Health Act 1983 (16 December 2013), and was completed by a member of the intensive support team. There was an additional entry which documented a series of incidents that occurred in November 2013. These included:

- Ian disclosed details of an accident that he had sustained after drinking a considerable amount of alcohol and taking his medication (Amisulpride) in "an attempt to knock himself out".

- A series of incidents of disinhibited sexually inappropriate behaviours involving several female tenants and on one occasion a daughter of a female tenant who was under the age of 18 years.[264]

- Ian had made threats to kill a female tenant and her boyfriend, as he reported that they owed him money.

[258] Point-in-time Risk summary –point in time October 2013 p3
[259] Risk summary –point in time October 2013 p3
[260] Risk summary –point in time October 2013
[261] Due to the electronic layout of the risk summary, it is not possible to conclude if the risk ratings were from the assessment undertaken in 2012 or 2013; we have assumed the latter
[262] Risk summary –point in time p1 AWP's risk rating definition of medium
[263] AWP's Risk Summary format had changed, and from this point it was called a 'Risk Summary -point in time
[264] Risk summary entry 16 December 2013 p4

- Despite these recent incidents, it appears that Ian's risk ratings had not altered from the previous assessment.

- The risk formulation sections were not completed.

11.6 Ian's risk summary –point in time was reviewed again on 16 December 2013, following his arrest for the assault on Kamil and his subsequent detention under Section 2 of the Mental Health Act 1983. The assessment identified that there had been "an unprovoked assault on Kamil, a fellow resident of Kurdish origins"[265], and also a threat to a member of staff at the supported housing service when Ian was intoxicated.

11.7 The assessment concluded that:

- Ian's risk of harm to others and overall risks were assessed as being "high"[266]: "current indicators of risk are present suggesting that the risk outcome could occur at any time"[267].

- Ian's risk of harm to self and evidence of other risk behaviours were low.

- The risk formulation sections were not completed.

11.8 Two different risk summary forms were completed. Both documented the same information and scored the same rating.

11.9 Although there was no evidence of a risk management plan being completed either prior to or during this inpatient admission, there were the following entries in Ian's care plan overview:

- no lone female working

- male key working team

- for close assessment during initial phase and then ongoing assessment and observations, in addition, "If risks present and cannot be managed the consideration of male PICU bed for protection of [Ian] and others".

- to monitor for signs of alcohol withdrawal.

All actions were due to commence on 17 December 2013.

11.10 There was no evidence that any further risk summaries-point in time or risk entries were made on Ian's care plan review either during Ian's admission to the inpatient unit or at the point of his discharge (29 January 2014).

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[265] Risk summary entry 16 December 2013 p3

[266] Risk summary entry 16 December 2013 p5

[267] Risk summary p1 AWP's risk rating definition of high

11.11 There were, however, several risk-related entries and associated risk management plans dated 5 March 2014 in the care plan overview. These included:

- to minimise the risks of serious harm to others when [Ian] was unwell or intoxicated – these included talking and asking for support
- to have Ian's] physical health monitored by his GP
- Ian "to stop being abusive towards his fellow residents … [Ian] to curtail his drinking and to explore other accommodation with higher support"[268].

The care coordinator was cited as the main person responsible for supporting Ian to manage these risks.

11.12 There was no evidence to indicate if alternative accommodation options were being considered.

11.13 There was also no evidence that Milestones Trust staff were involved in the risk assessments or that they received a copy of the updated assessment and plan.

11.14 It was documented that the next risk review was scheduled for 7 October 2014. No evidence was presented to the investigation team to indicate that this scheduled risk review occurred. In fact, the next Risk Summary –point in time was not undertaken until 30 March 2015. This summary was completed by the recovery navigator at the point she began to support Ian.

11.15 The summary assessed that the risks of harm to self, of harm from others and of accidents were low.

11.16 Ian's risk of harm to others was assessed as medium. This section documented all of the incidents from 1991 to 2013 that were in the previous summary. It was documented that there were "no current or additional concerns, continuing use of alcohol (contributory factors in previous incidents)"[269].

11.17 Unlike the previous Risk Summary–point in time, the risk incident section was a copy of Ian's progress notes from 8 October 2013 to 15 October 2013. This documented a number of risk incidents, including actual assault, aggression and other risk behaviours. It was unclear why the incidents that led up to his hospital admission on 16 December 2013 were not documented.

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[268] Care plan overview : entries 5 March 2014 p2-3

[269] AWP Risk Summary-point in time 20 March 2015 p3

11.18 There was no indication that Milestones Trust support staff or Ian's GP were involved in this assessment or that they received a copy of it.

11.19 It was documented that the next scheduled Risk Summary- point in time was scheduled for 7 October 2015; however, there is no evidence that this review occurred.

11.20 During an assessment and recovery team cluster meeting (30 March 2016), it was documented that "a clear plan (including a relapse and management plan) was to be developed"[270]. There was no evidence to indicate that such a plan was developed.

11.21 The recovery navigator made several entries in an ongoing Core Assessment overview relating to Ian's substance and alcohol use and his mental health presentations, and also completed a My Crisis Plan on 27 May 2015. The plan cited the following:

- "Indicators that I am in crisis and others need to take responsibility for my care, keep me safe and make decisions on my behalf – changes in personality, becoming sexually inappropriate, aggressive/agitated. Physical symptoms – stopped taking clozapine, getting confused, bizarre and paranoid thinking, drinking alcohol every day."[271]

- Identified support from others – to support Ian to take his medication, and in the past being admitted to hospital.

- Activities that have been helpful in the past in times of crisis – a structured daily routine and talking to his support worker.

- The sections headed 'Indicators that things are breaking down for me and a crisis is looming', 'Warning signs', 'What I can do that is helpful to me when I am in crisis' and 'Things my team think have helped me stay safe' were not completed.

11.22 This was the only crisis plan that was completed in this format, and there was no indication that Milestones Trust support staff or Ian's GP were involved in developing this plan or received a copy of it.

11.23 No further Risk Summaries point in time were completed by the assessment and recovery team. However, during BCS's involvement (from December 2015 to January and June 2016), although no risk summaries were

[270] AWP progress notes 30 March 2016
[271] My Crisis Plan 27 May 2015

completed, there were entries within Ian's progress notes relating to his "potential risks towards other people "[272]. For example:

- 3 January 2016: Ian cited Kamil as "someone he strongly dislikes"[273], although he had made no direct threats towards Kamil.

- 6 June 2016: It was documented by a member of BCS that Ian had made threats to harm others in letters, which he had delivered to the supported housing scheme's office, towards specific people, including Kamil. Due to the potential risks, there would be no lone visiting by members of the AWP services.

11.24 During Ian's admission to AWP's inpatient unit, a Risk Summary-point in time was completed by members of the nursing staff. There were entries on 10 June and 16 June 2016. The risk summary included:

- Risk of harm to self – it was documented that in 2010 Ian had self-harm and suicidal thoughts. Also, in October 2013 Ian had consumed a considerable amount of alcohol with his medication amisulpride "in the context of wanting to sleep"[274] rather than as an intentional overdose or suicidal act. There was a brief summary of an incident in 2010 when Ian reported that he had wanted to self-harm when he felt under pressure to move to more independent accommodation. Ian also reported that in October 2013 he had self-medicated with alcohol and prescription medication to manage a period of insomnia. It was documented that from 2015 to his inpatient admission, Ian reported no suicidal or self-harming urges. His risk was assessed as low.

- Risk of harm from others – details of Ian's adverse reaction in December 2015 to clozapine was documented. The updated entry on 10 June 2016 stated that there were "no new risks identified in this area"[275]Ian's overall risk was assessed as low.

- Risk of harm to others: it was identified that there were risks to vulnerable adults, and a risk of violence/aggression and abuse to family, the general public, other clients and staff. This section documented details of Ian's forensic history, including two serious assaults, in 1987 and 1991, when he assaulted members of an inpatient unit's nursing staff; and six incidents of violent and disinhibited and sexualised behaviours, from 2013 to 2016, involving tenants from the supported housing scheme – three of these involved Kamil, who it was noted was of "Kurdish origin"[276]. It was

[272] AWP progress notes 23 December 2015
[273] AWP progress notes 3 January 2016
[274] AWP Risk Summary-point in time 10 June 2016 p3 [275]
AWP Risk Summary-point in time 10 June 2016 p3 [276]
AWP Risk Summary-point in time 10 June 2016 p4

documented: "query racially driven attack – in the context of [Ian's] alcohol use and paranoid ideation"[277]. The overall risk to others was assessed as high.

- Other risk behaviours: this section included details of several incidents when Ian absconded from inpatient units from 1988 to 1989; his adverse blood response to clozapine; and the decision made by community services, prior to his latest admission, that due to his level of risk, he was only to be seen in communal areas and with two members of staff. It also documented that Ian had a "low threshold for admission due to potential risk to other residents and staff."[278]

- Ian's overall risk rating was high.

11.25 This Risk Summary-point in time was forwarded to Cygnet Health Care as part of AWP's referral information. Included in Risk Summary-point in time were copies of Ian's progress notes from the admission. these included the following:

- Details of Ian's recent sexualised and threatening behaviours.

- The admitting doctor noted that Ian had "limited insight [and] said he would not harm anyone but evidence from section paperwork [is] to the contrary"[279]. It was also documented that Ian had been a patient for 20 years in two high- secure hospitals.

- Ian disclosed (on 18 June 2016) that he had experienced auditory hallucinations since he was a teenager but that they were not currently causing him any distress.

- There was a copy of an email sent by the AMHP (15 June 2016) who had been involved in Ian's Mental Health Assessment 1983, which highlighted concerns about Ian's disclosure while he was in police custody regarding "14- year-old girls and paedophilia"[280]. The AMHP reported that the custody sergeant was referring Ian's disclosure to his investigation team. The AMHP also reported that the assessment team had concerns regarding Ian's "potential risk to children and young women and would advise that a full risk assessment [was] undertaken [in] respect of these potential risks"[281]. This disclosure was highlighted in the Risk Summary-point in time, which was reviewed the following day.

[277] AWP Risk Summary-point in time 10 June 2016 p4 [278]
AWP Risk Summary-point in time 10 June 2016 p5 [279]
AWP progress notes 4 June 2016 1.42am
[280] Email from AMP to inpatient unit 15 June 2016
[281] Email from AMP to inpatient unit 15 June 2016

- Apart from several entries which commented that Ian's responses to the inpatient unit's staff were overtly sexualised and inappropriate, there were no significant incidents documented.

11.26 The admitting doctor and ward staff made several brief entries in AWP's rolling care assessment (14 and 23 June 2016), which contained information about Ian's family and personal history, mental state examination, and historic and current physical health. There is no indication that the core assessment was forwarded to Cygnet Health Care as part of the referral information.

Comments and analysis

11.27 It was comprehensively documented that there was always a significant escalation in Ian's risks when he had to stop taking clozapine or when he was non-compliant with his medication regime. These periods were often accompanied by a reported increase in Ian's alcohol consumption and substance misuse. At such times, there was a significant escalation in his antisocial, aggressive and disinhibited sexualised behaviours , which, from 2013, was mostly directed towards either Kamil or other tenants at the supported housing scheme.

11.28 All the agencies involved in assessing and supporting Ian were aware that he had a significant forensic history, which included two unprovoked and serious assaults on nurses, and that he had spent 20 years in high-secure hospitals. These risk factors were documented in AWP's patient records and Milestones Trust's records, and this information was provided as part of Ian's referral to Cygnet Health Care's inpatient unit.

11.29 During the course of the investigation, there was evidence that the involved AWP and Milestones Trusts practitioners were, in the main, responsive in providing increasing support to Ian at times when his mental health was deteriorating, and his risks were perceived to be escalating. Forexample:

- BCS were involved during times of crisis in order to provide additional levels of support and monitoring.

- The practitioners ensured that Ian was having the required ongoing blood tests in order to monitor him for any potential adverse response to the clozapine medication. There was always a prompt response when there were amber and red blood alerts.

- At times of crisis and to ensure full compliance, both the recovery navigator and members of the BCS would deliver Ian's medication on a daily basis.

- When there were increasing concerns about Ian's mental health and risk factors, the consultant psychiatrist from the assessment and recovery team

visited Ian at his accommodation in order to assess and monitor his mental health and risk factors.

- Additionally, both the consultant psychiatrist and the recovery navigator provided ongoing advice to the supported housing scheme staff as to how to manage Ian's escalating risks and the safety of the tenants.

11.30 Deficits in risk and care planning were highlighted in a CQC inspection that occurred in December 2015. The inspection report concluded that AWP's

"Bristol community and assessment teams were not effective or safe … Assessments were not always carried out in a timely way. Some patients did not have risk assessments or risk assessments were not linked to patients' care plans … others had plans of poor quality. In some cases, care plans were out of date … we found that the Bristol community assessment and recovery services were not safe."[282]

11.31 The inspection report also noted that:

"The local commissioning group and local safeguarding adult team told us they were also concerned about the poor performance of services and that patients may be at risk."[283]

11.32 After issuing a section 29, the CQC undertook a further inspection in February 2016, which concluded that:

"The trust had revised its governance structure within Bristol to focus on gaining detailed assurance that all teams were delivering safe and effective care in a timely manner. The trust had introduced new governance groups across Bristol."[284]

11.33 The next CQC inspection in 2018 reviewed risk management at Bristol's Intensive service and concluded:

"We reviewed 45 care records and saw that staff regularly updated risks and completed appropriate risk assessments. Staff had in-depth conversations about patients risk weekly, as well as in the hand over each day."[285]

11.34 The investigation team agreed with the conclusion reached by the authors of AWP's SI report, which was that:

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[282] CQC Inspection Report December 2015 and February 2016 CQC report 2015

[283] CQC Inspection Report December 2015 and February 2016 CQC report 2015

[284] CQC Inspection Report December 2015 and February 2016 CQC report 2015

[285] CQC inspection report 2018 p30

"Given [Ian's] medical history and high-risk profile his care plans and risk assessments were not as comprehensive as expected."[286]

The investigation team would also suggest that the evidence indicates that there were concerning deficits in the quality and contents of Risk Summaries –point in time and assessments that were undertaken.
These included:

- Ian's last Risk Summary–point in time was completed on 30 March 2015, and there was only one crisis plan, which was completed on 27 May 2015. Both were completed by a recovery navigator from the assessment and recovery team. However, AWP's CPA and Risk Policy states:

  "The Care Coordinator is responsible for ensuring that review meetings take place at the relevant times. There is a minimal requirement to undertake an annual review the best practice interval of 6 monthly reviews will be achieved or earlier at whatever time it becomes necessary."[287]

  Ian's risk and care planning reviews were neither being reviewed annually nor being re-evaluated in response to particular incidents when there was evidence that there was an escalation in Ian's risks. For example:

- When Ian's clozapine had to be stopped and it was well documented that historically this had always triggered a significant relapse in his mental health and an increase in his potential risks of harm to others.

- In response to Ian's disclosures that his substance and alcohol misuse was increasing again, which was a known significant risk indicator.

- When the supported housing scheme's staff were reporting incidents of Ian's sexually inappropriate behaviours, threats and actual physical assaults on other vulnerable tenants, including Kamil.

- When the supporting housing service was indicating that they were seeking to serve Ian with an eviction notice, as they could no longer provide the support that he was requiring and his risks to the other vulnerable tenants could no longer be managed.

All of the above should have prompted a review of both Ian's Risk Summary-point in time and his care plan.

[286] AWP's SI report p3
[287] AWP's CPA and Risk Policy p8

11.35 The investigation team were informed that when a patient on a CPA in the assessment and recovery team is considered to be stable and at the lower end of risk(s), they can be 'stepped down'[288], and their ongoing support can be provided by a recovery navigator. In such cases, the care coordinator maintains the overall responsibility for the patient, such as arranging CPA reviews and undertaking risk reviews. However, if a patient who is being supported by a recovery navigator begins to exhibit signs of a mental health relapse and/or their risk factors have been assessed as increasing, they are 'stepped up'[289] to one of the more senior practitioners in the team, who will assume a care coordinating role.

11.36 There was no evidence of Ian's care coordinator assuming a care coordinating role, supervising the content of the assessments that were undertaken by the recovery navigator or ensuring that the assessments and care plans were being reviewed as per policy and in response to Ian's escalating risks. This was particularly concerning to the investigation team, when it was clearly evident that from November 2015 to Ian's admission to the inpatient unit (June 2016), there was a significant increase in his risks, especially with regard to his risk of harm to others. Additionally, it was also evident to the team that Ian was experiencing a significant deterioration in his mental health and had disclosed that his alcohol and substance misuse had increased.

11.37 The investigation team have concluded that from November 2015, such was the level of Ian's risk indicators, in combination with an increasing absence of protective factors, that a senior and clinically qualified member of the assessment and recovery team should not only have assumed an overall care coordination role but should have been reviewing Ian's Risk Summary-point in time and crisis plans on an ongoing basis.

11.38 During an assessment and recovery team meeting on 30 March 2016, it was documented that "a clear plan (including a relapse and management plan) was to be developed"[290]. This did not occur, and it was not evident who was delegated this role or if there was any managerial or clinical monitoring in place that could have highlighted that this had not occurred.

11.39 There was no evidence that Milestones Trust's supported housing staff were asked to contribute to the Risk Summaries-point in time that were undertaken by AWP's recovery and assessment team or during Ian's AWP and Cygnet Health Care inpatient unit admissions. The investigation team would suggest that this was a significant and ongoing error, as they could have provided

[288] Step down – when a service user requires a lower level or no intervention from AWP
[289] Step up – when a service user requires a higher level of intervention from AWP
[290] AWP progress notes 30 March 2016

valuable information about Ian, the risks that he was posing to other tenants and the suitability of the placement. Milestones Trust also did not receive a copy of the Risk Summaries- point in time. Again, this would have been extremely helpful, not only in the management of Ian and his risks to other tenants, but also to inform their housing management decisions – for example, actioning their eviction procedure.

11.40 There was only one occasion (5 March 2015) when it was documented that Ian's GP had been asked to contribute to the Risk Summary –point in time review. There was no indication that the GP was sent a copy of the Risk Summary –point in time reviews or details of the assessment. Again, this was a significant error, as the GP could have provided important information about their observations and involvement, which would have informed Ian's Risk Summary –point in time reviews.

11.41 Also, it would have been helpful for Ian's GP to have up-to-date information about Ian's risks to inform their involvement. For example, it was reported to the investigation team that lone-working female GPs had visited his accommodation in January 2016 and that they had not been aware of Ian's escalating risks and the decision that had been made by AWP that there should be no lone working.

11.42 The lack of interagency involvement in risk assessments is contrary to the clear directive within AWP's CPA and Risk Assessment policy that states:

"Reviews of care should take place with the service user and any other relevant people involved in their care."[291]

11.43 The Department of Health's (hereafter referred to as DH) Best Practice in Management Risk stresses the importance of multi-agency involvement in the assessment of risk, in order to:

"Identify predisposing, precipitating, perpetuating and protective factors, and also how these interact to produce an elevation in risk. This formulation should be agreed with the service user and others involved in their care in advance, and should lead to an individualised risk management plan … The process is ongoing and dynamic, and for it to be truly effective, all members of the multi-disciplinary team involved in the patient's care need to contribute … The plan should also include more general aspects of management, such as monitoring arrangements, therapeutic interventions, appropriate placements and employment needs."[292]

[291] AWP's CPA and Risk Policy p8

[292] Best Practice in Managing Risk p20

11.44 The investigation team noted that AWP's CPA and Risks policy did not provide clarity with regard to the role of recovery navigators and care coordinators, especially in situations in which a patient's risks are escalating.

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)

Recommendation 3: AWP should undertake an urgent review of their CPA and Risk Policies to ensure that they provide clarity regarding recovery navigators' responsibilities in relation to care coordination and the assessment of risks.

11.45 The investigation would suggest that in a situation where a care coordinator and a recovery navigator are holding joint responsibility for a patient, there should be regular joint supervision sessions to ensure that the appropriate level of risk assessment and care planning is being provided. This would also provide the opportunity to identify when either risk factors or support needs have increased and require a clinical practitioner to be involved.

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)

Recommendation 4: When a patient is receiving support from both a care coordinator and a recovery navigator, regular joint supervision should be undertaken to ensure that an appropriate level of risk assessment and care planning is being provided and to identify when the involvement of a senior clinical practitioner is required.

11.46 The investigation team would also suggest that AWP considers updating its Risk Summaries-point in time pro forma to ensure that a more robust and systemic risk assessment is developed that involves all involved services working in partnership with AWP. Such an assessment should include the following:

- A narrative of all risks identified, with an explanation as to why the assessor has scored the risk high, medium or low.
- Highlight where there are deficits of information and what action(s) the assessor is going to take to obtain the information. Until such information is obtained and assessed, the associated risks should be assessed as high.
- Contact details of all agencies involved in the assessment.

- Based on the information obtained in the risk assessment, a risk management plan should be developed that clearly highlights who may be at risk and what action(s) needs to be taken to reduce or eliminate the potential risks – for example, a staff safe working action plan, or reporting a risk to the safeguarding team.

- A Safety Crisis plan should consider all the high and medium risks that have been identified within the risk assessment.

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)

Recommendation 5: AWP should develop a more comprehensive Risk Summary point in time pro forma.

11.47 This section covers the following NHS England ToR:

"Review the risk assessment and risk management plans in place at the time of the incident, with particular reference to risks posed to the victim, and other vulnerable adults and whether they were appropriately shared and understood by all agencies involved in the care and treatment of [Ian].

Review the appropriateness of the decision-making processes and outcomes with specific reference to the transfer between inpatient services

Review the effectiveness of communication, information sharing and decision making between agencies."[293]

In light of the evidence available, the investigation team have concluded the following:

- The risk assessments and risk management plans undertaken by members of the assessment and recovery team were not adequate and were also non-compliant with AWP's CPA and Risk policy and best practice guidelines.

- The lack of Risk Summary-point in time reviews and the absence of a risk management plan by the assessment and recovery team were of particular concern, especially in the months leading up to Ian's last inpatient admission, when it was known that Ian's risks were significantly escalating, particularly in relation to his risk of harm to other tenants, including Kamil.

[293] NHS England Terms of Reference p1

- Ian's escalating risks from January to June 2016 did not trigger a review of his Risk Summaries-point in time or his Crisis Plan by the assessment and recovery team.

- There was a lack of involvement of other agencies in the Risk Summaries – point in time assessments that were undertaken by both the assessment and recovery team and AWP's inpatient unit.

- There was evidence of information sharing between the recovery navigator and Milestones Trust's supported housing staff at times of crisis. However, there were deficits in the involvement of the other involved agencies, such as primary care, as well as in the sharing of information with them, namely the information from the risk assessments that were undertaken by the assessment and recovery team and AWP's inpatient unit.

- Ian's care and the assessment of risk were not stepped up from the recovery navigator to a senior qualified member of staff within the assessment and recovery team when it became evident that his risks to both himself and others were significantly escalating.

- The lack of an up-to-date care plan resulted in there being no contingency or crisis plans.

- AWP's inpatient unit provided Cygnet Health Care with a considerable amount of information regarding Ian's inpatient admission – for example, his most recent Risk Summary –point in time and copies of his inpatient progress notes. However, what was lacking was detailed information about Ian's pre- admission and also detailed psychiatric assessments.

- A multiagency risk assessment and management plan should have been undertaken where information could have been shared between agencies and a crisis management plan agreed.

- It was evident that there was a consistent lack of information sharing between AWP's community mental health services and Milestones Trust. It was reported to the investigation team that despite meetings having taken place since the incident there still remains a lack of consistency with regard to information sharing that the investigation team suggest needs to be addressed.

- Given the known risks, both historic and current, the investigation team would have expected that Ian's risks were assessed as high at times when his clozapine had to be stooped and when his mental health was deteriorating.

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)

Recommendation 6: AWP should establish an information sharing protocol between all agencies involved in the provision of services within Bristol Mental Health

12 Cygnet Health Care risk management and care planning

12.1 On 20 June 2016, due to AWP bed management issues, Ian was transferred to Cygnet Health Care's PICU.[294] As has already been reported, based on the evidence provided to the investigation team, the following information was forwarded as part of the referral information to Cygnet Health Care:

- AWP's inpatient unit's Risk Summary –point on time assessment, completed on 16 June 2016.
- copies of Ian's inpatient progress notes
- a copy of the AMHP's handwritten report from Ian's Mental Health Assessment 1983 on 13 June 2016
- Cygnet Health Care's referral form documented a brief summary of Ian's historic and current presentation and the events that led up to his Mental Health 1983 assessment.

12.2 The following assessments were completed by the admitting doctor:

- Brief Psychiatric Rating Scale (BPRS)[295]. The following were assessed as being present:

  3 mild: elated mood, grandiosity, suspiciousness, tension
  2 very mild: excitement and distractibility
  1 not present: hallucinations, unusual thought content and bizarre behaviour

[294] CQC's last two inspections of Cygnet Health Care's PICU and the acute ward where Ian was a patient assessed each area as well as the overall rating as "good"

[295] The Brief Psychiatric Rating Scale (BPRS) is a rating scale which a clinician or researcher may use to measure psychiatric symptoms such as depression, anxiety, hallucinations and unusual behaviour. Each symptom is rated 1-7, and, depending on the version, a total of between 18 and 24 symptoms are scored. The scale is one of the oldest, most widely used scales to measure psychotic symptoms and was first published in 1962. Severity range scoring: 1 not present, 2 very mild, 3 mild, 4 moderate, 5 moderate severe, 6 severe, 7 extremely severe BPRS

- A Short-Term Assessment of Risk and Treatability Assessment (START)[296] and risk formation was also completed. It was assessed that:

  Ian's mental state and medication adherence was a "critical Item"[297].

  Specific Risk Estimates section (within the given time frame, if given the opportunity) was assessed as "low risk"[298] for violence, self-harm and suicide.

  The risk formulation section documented the following information:

  Violence: Ian's "risk of violence increases when his mental state is poor, if he is experiencing command hallucinations then he is at increased risks of causing harm to others"[299].

  Substance abuse: when Ian "uses cannabis or other substances there is a high chance that he will experience deterioration in mental state and as a result will be at increased risk of aggression, self-neglect and self-harm"[300].

- The 'Risk history details' section provided a brief summary of Ian's forensic history from 1977 to 1991 and a more detailed summary of the following incidents involving Kamil and other tenants:

  "2013 [Ian] punched 7 times a fellow resident in the face due to the other person cutting the cable of the TV. Sustained a bruised eye to the other person.
  2013 there were a series of incidents reported by a female resident.
  2013 unprovoked verbal and physical assault of another resident in supported accommodation.
  2016 highly sexually disinhibited behaviour masturbating in public areas
  2016 turned conversation into sexualised nature."[301]

- The planned management strategies to inform care plan' section documented the following:

  "Medication adherence: to encourage [Ian] to take his prescribed medication and this will hopefully give him insight into his behaviour.

[296] START (Short-Term Assessment of Risk and Treatability) is a concise, clinical guide to the assessment of short-term risk for violence and treatability. The START is a concise clinical guide for the dynamic assessment of short-term (i.e., weeks to months) risk for violence (to self and others) and treatability. START
[297] START 20 June 2016 p2
[298] START 20 June 2016 p2
[299] START 20 June 2016 p2
[300] START 20 June 2016 p2
[301] START 20 June 2016 p2

To offer [Ian] 1:1 sessions where he explores his thoughts and feelings that promotes therapeutic relationships.
To educate [Ian] about acceptable behaviours and boundaries and for him to gain insight into his noncompliance can make him unwell and hostile and aggressive.
To advocate for section 17[302] in the MDT when necessary.
To encourage [Ian] to attend the ward activities and promote interaction with others."[303]

12.3 A handwritten Mental State Examination was completed, which documented that:

- Ian had experienced auditory command hallucinations. They were "giving him commands to make threats to kill"[304] and he had experienced "delusions with sexual contents"[305].

- It was also documented that he made a disclosure about an incident that occurred when he was six years old. It was noted that "this needs further investigation by the safeguarding team"[306]. However, there was no evidence that this was reported or investigated by the safeguarding team. As this document was not signed or dated, it is not possible to position it chronologically within the inpatient admission process.

12.4 A multi-disciplinary care plan was completed on 20 June 2016 by a member of the ward staff. It documented that Ian's recovery star[307] domain was "managing mental health"[308]. The plan identified specific, measurable, achievable, relevant and timely (SMART) goals to assist Ian with his recovery. The goals included compliance with his medication, engaging with the therapeutic support and activities on the ward. Ian signed this plan.

12.5 A further START assessment and risk formation was completed on 29 June 2016, when Ian was moved to the open acute ward. The 'numerical scoring of risks' section of the assessment was not completed. The following areas were documented in the risk formulation section:

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[302] Section 17 of the Mental Health Act (1983), which allows the Responsible Clinician (RC) to grant a detained patient leave of absence from hospital. Section 17
[303] START 20 June 2016 p1-3
[304] Mental state examination was not signed or dated
[305] Mental state examination
[306] Mental state examination
[307] The Recovery Star is designed for adults managing their mental health and recovering from mental illness. The 'star' contains ten areas covering the main aspects of people's lives, including living skills, relationships, work, and identity and self-esteem. Service users set their personal goals within each area and measure over time how far they are progressing towards these goals. This can help them identify their goals and what support they need to reach them, and ensure they are making progress, however gradual. Recovery star
[308] Multidisciplinary care plan 21 June 2016 p2

- Violence: it was documented that Ian had "an extensive history of violence and aggression. However, there have been no documented incidents since 2013 and he has been settled throughout his admissions during June. Therefore [Ian] is deemed low risk of violence currently."[309]

- Substance abuse: it was documented that Ian was "at low risk of substance abuse during admission and escorted leave. However, when discharged or if [Ian] gains unescorted leave this could increase to moderate. This in turn could increase his risk of self-neglect, self-harm, sexual disinhibition, violence and aggression."[310]

- Sexual disinhibition: it was documented that there had been "no incidents of sexual disinhibition since his recent admission, therefore his risk is deemed to be low. However, should his mental state deteriorate this would increase to moderate/high as this was the case of his admission."[311]

- Specific Risk Estimates – documented the following risks as being "low"[312]:

  Risks of violence. Self-harm. Suicide. Unauthorised leave. Substance abuse. Self-neglect. Being victimised. Sexual disinhibition.

- The planned management strategies to inform care plans were cited as:

  "Encourage medication compliance
  [Ian] to have 1 to 1 time with staff
  To educate [Ian] about acceptable boundaries and behaviours
  Encourage [Ian] to utilise Section 17 leave
  To encourage engagement in ward activities
  To nurse [Ian] on prescribed observations to monitor his mental state."[313]

- The 'risk history detail' section documented details of incidents of historic violence in 1987, 1988 and 1991. It also documented details of the incident in 2013 in which Ian had assaulted Kamil, and:

  "a female resident living next door to [Ian] reported a series of incidents, incidents of unprovoked verbal and physical assaults on a neighbouring resident in his supported housing"[314].

[309] START 29 June 2016 p2
[310] START 29 June 2016 p2
[311] START 29 June 2016 p2
[312] START 29 June 2016 p1
[313] BPRS 20 June 2016 p2
[314] START 29 June 2016 p2

12.6 On 29 June 2016, another BPRS was completed by one of the speciality doctors[315] – all areas were now assessed as being 1 (not present), apart from anxiety and elated mood, which were scored as 2 (very mild).

12.7 Ian's care plan was reviewed, with recovery star domains identified as managing mental health with the addition of trust and hope, identity and self-esteem.

12.8 The care plan also documented that "following [Ian's] tribunal a plan was made for him to be discharged on 6 June 2016 at 4 p.m. Staff will support [Ian]."[316]

Commentary and analysis

12.9 The referral information that was sent by AWP's inpatient unit to Cygnet Health Care was quite comprehensive. It included their latest Risk Summary– point in time, which documented details of:

- Ian's risk and forensic history
- the events that led to his detention under a Section 2 of the Mental Health Act 1983
- a possible "racially motivated and unprovoked"[317] attack on Kamil
- Ian's exhibition of highly sexualised disinhibited behaviours in public areas of the supported housing scheme and "threats to kill residents, staff and the public"[318].
- Ian's disclosure while in police custody about a "14-year-old girls and paedophilia … the assessment team were concerned about [Ian's] potential risks to children and young women."[319]

12.10 The investigation team have concluded that a comprehensive number of mental health, risk and support assessments were undertaken by Cygnet Health Care's inpatient unit. However, the focus of these assessments was on the inpatient admission, and until the day of Ian's discharge, there was no assessment or consideration by the inpatient staff of his support needs or risk(s) after his discharge.

[315] Specialty doctor: the specialty doctor post is not a training grade; it is a grade where a doctor has at least four years of postgraduate training, two of those being in a relevant specialty
[316] CARE plan 29 June 2016 p3
[317] AWP risk summary 16 June 2016
[318] AWP risk summary 16 June 2016
[319] AWP risk summary 16 June 2016

12.11 It was noted that there was some disparity in the information that was documented in the two START assessments with regard to Ian's more recent risk history. For example:

- The initial START provided information about several incidents that had occurred in 2015 and leading up to Ian's detention under the Mental Health Act 1983 (June 2016), which included physical aggression and multiple threats towards other tenants and staff, and sexually disinhibited behaviours.

- The second START assessment documented that "there have been no documented incidents since 2013"[320].

  The investigation team would suggest that this was a significant error, especially given that the incidents of aggression were so recent and related to the safety of other vulnerable persons who were living with Ian. This information should have alerted the ward and clinical staff that a discharge plan needed to be developed with all of the involved agencies.

12.12 Although Ian's last care plan documented that the ward staff were to support Ian with his discharge, there is no evidence that this occurred. AWP's SI report commented:

"It seems pertinent that [Ian's] return to that environment be a key element of the risk assessment. However, there is no record of any conversation with [Ian] regarding his presentation and behaviour leading up to his hospital admission. There is no record in the risk summary or care plan of how he felt about returning to the accommodation or how he felt about the people he had allegedly made threats to kill."[321]

Neither AWP nor Cygnet Health Care addressed this issue with Ian prior to his discharge back to Milestones Trust's supported housing scheme. This deficit the investigation team would suggest should have been cited as a contributory factor in either AWP or Cygnet Health Care's SI reports.

12.13 One of the findings of Cygnet Health Care's SI report was that "little information was received about [Ian's] previous history or his behaviour since [his] admission to Hazel Ward"[322]. The investigation team does not totally agree with this finding, as a reasonable amount of information was forwarded

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[320] START 29 June 2016 p2

[321] AWP SI report p4

[322] Cygnet Health Care SI report p20. One of the recommendations of the SI reports was "that the Cygnet Kew stoke team arrange a meeting with AWP to discuss how going forward all information can be made available and post admission where the team should be targeting their requests". An update on the progress that has been made on this recommendation is in Section 4.

as part of the referral from AWP's inpatient unit. However, what Cygnet Health Care's SI report did not seek to identify or consider was why the ward or clinical staff did not, at any point, make direct contact with either Milestones Trust or AWP's assessment and recovery team in order to obtain information about Ian and the situation prior to his Mental Health Act 1983 assessment. This, was a significant missed opportunity, as obtaining such information from Ian's housing provider would have informed.

- Cygnet Health Care's inpatient risk and mental health assessments

- the consultant psychiatrist's report to the Mental Health Tribunal.

12.14 It should also be stated at this point that it was not only Cygnet Health Care but also AWP's assessment and recovery team and Milestones Trust who failed to take any proactive steps to make contact with the other involved agencies in order to share information and to discuss a planned discharge plan that would provide adequate support to Ian and minimise any potential risks to Ian and the other tenants.

12.15 The investigation team also suggest that as Cygnet Health Care are still commissioned to accept a number of AWP's patients, consideration should be given to allowing them to have electronic access to the patient's AWP records. The investigation team are aware that at least one of the agencies within Bristol Mental Health has this facility. Clearly, this would address the issue that has been highlighted in this incident of adequate information not being accessible, but it would also ensure more continuity of care when an AWP patient is transferred between the two sectors.

Avon and Wiltshire Mental Health Partnership Trust (AWP) and Cygnet Health Care

Recommendation 7: AWP should consider the feasibility of allowing Cygnet Health Care's inpatient unit to have access to a patient's AWP records.

12.16 With regard to the following NHS England ToR:

"Review the risk assessment and risk management plans in place at the time of the incident, with particular reference to risks posed to the victim, and other vulnerable adults and whether they were appropriately shared and understood by all agencies involved in the care and treatment of [Ian]

Review the appropriateness of the decision-making processes and outcomes with specific reference to the transfer between inpatient services.

Review the effectiveness of communication, information sharing and decision making between agencies.

"Review the appropriateness of the decision-making processes and outcomes with specific reference to the transfer between inpatient services."[323]

The investigation team have concluded that:

- Information provided by AWP's inpatient unit to Cygnet Health Care's inpatient unit was reasonably comprehensive.
- Cygnet Health Care's inpatient unit undertook a number of comprehensive assessments in relation to Ian's risks and support needs at the point of Ian's admission and during his stay on the unit.
- There were consistent failures to obtain further information about Ian's risks, psychiatric assessments and potential risks of harm to other tenants from either AWP's assessment and recovery team or Milestones Trust. This information could have been utilised to inform both Cygnet Health Care's assessments and the reports that were completed for the Mental Health Tribunal.
- The focus of Cygnet Health Care's assessments was on the inpatient admission, and until the day of Ian's discharge, there was no assessment or consideration by the inpatient staff of his support needs or risks after his discharge. This was despite there being the opportunity after the Mental Health Tribunal to liaise with the other involved agencies.
- As has already been stated, all the involved agencies had a responsibility to instigate contact with other agencies in order to share information, seek further information and discuss a discharge plan that provided adequate support to Ian and minimised any potential risks to both Ian and the other tenants.

13 Milestones Trust's risk management

13.1 At the time of the incident, Milestones Trust's supported housing scheme were using handwritten daily diary entries to document a tenant's daily activities, contact with staff, appointments and any particular concerns. Staff reported that it was expected that they would access these entries if they needed up-to-date information about a tenant. Entries were stored in a file in a locked cabinet located in the staff office at the service.

[323] NHS England Terms of Reference p1

13.2 An additional file was also kept for each tenant service, which contained copies of:

- incident forms and action taken
- safeguarding reports
- warning letters
- email correspondence to other agencies with regard to particular incidents and housing management actions.

Commentary and analysis

13.3 The investigation team were given access to both Ian's and Kamil's files. They noted the following:

- The handwritten daily diary entries were frequently difficult to read due to the standard of writing.
- Entries were very varied in their content.
- There was no assessment or consideration of risk or risk planning.
- There was no correlation or cross-referencing between the two files; therefore, it was difficult to develop a comprehensive chronology of events, risk factors or risk planning, action being taken, or support being provided.

13.4 Milestones Trust's management report, which was completed for the SAR by their director of operations, concluded that:

> "The written documentation in the files for the tenants was limited. In particular there was a lack of a formal risk assessment process. Where risk had been identified there was no risk management plans in place. Despite this, the evidence was that appropriate actions were taken to address risk."[324]

13.5 The investigation team would agree that there was considerable evidence to confirm that members of the supported housing scheme support staff and the management team were:

- initiating fairly regular contact with Ian's care coordinator, recovery navigator and members of the BCC

[324] SAR agency report Milestones Trust p24

- assessing and reporting potential risks posed by Ian to other tenants, including Kamil, via the safeguarding reports.

13.6 However, the investigation team were concerned that in their opinion at the time Milestones Trust's lack of a robust record-keeping and risk assessment process and that it was not until this tragic incident occurred that this deficit was highlighted and remedial action taken by their senior management team.

13.7 Milestones Trust's SAR management report stated that there was to be a:

"Review [of] Milestone risk assessment and management process to ensure that when risks are identified suitable plans are in place to manage them"[325].

13.8 During the course of Sancus Solutions' investigation, members of the supported housing scheme made reference to a more enhanced risk assessment and management planning processes that has since the incident been introduced: This included:

- A number of risk management plans such as a mental health risk management plan, in which both historical and current risks are documented, and a group risk management plan, in which any potential risks associated with the tenant group are assessed.

13.9 However, it was reported to the investigation team that:

- Some of the operational staff had concerns about the number of risk assessments that they are now expected to reference. The investigation team were of the opinion that the new risk assessment process is an administrative burden managers and support staff.

- Milestones Trust do not routinely share risk assessments and risk management plans with other agencies.

13.10 The investigation team would suggest that there is a danger of a lack of cohesion where multiple assessment forms are being completed. Therefore, they would suggest that Milestones Trust undertakes a further review of their current risk assessment process to consider a more recognised assessment tool that is more closely aligned with AWP's risk assessment.

13.11 Currently Milestones Trust electronically monitor support staff when they are lone working in the community, the investigation team were informed that at the initial assessment of a tenant any lone working potential risks are highlighted and addressed. It was also reported that since this incident Milestones Trust has introduced have reviewed their lone working risk

325 SAR agency report Milestones Trust p26

assessment protocol to ensure that risks are being continually assessed and monitored.

Milestones Trust

Recommendation 8: Milestones Trust should adopt a comprehensive risk assessment tool that is used by either statutory services or other third sector agencies.

13.12 In response to the following NHS England ToR:

"Review the risk assessment and risk management plans in place at the time of the incident, with particular reference to risks posed to the victim, and other vulnerable adults and whether they were appropriately shared and understood by all agencies involved in the care and treatment of [Ian].

Review the appropriateness of the decision-making processes and outcomes with specific reference to the transfer between inpatient services.

Review the effectiveness of communication, information sharing and decision making between agencies."[326]

The investigation team have concluded that Milestones Trust:

- Did not have adequate risk assessment and risk management plans in place at the time of the incident.
- After Ian was detained the inpatient unit staff at the supported housing scheme made no effort to contact AWP or Cygnet Health Care's inpatient unit either to provide information or to ascertain information about Ian's admission,
- The risk assessment process that has been introduced since this incident was reported by the support workers to be difficult to locate information due to the number of assessments that are now completed.
- The investigation team also concluded that the new risk assessment is not aligned with other agencies' risk assessment processes.
- Risk information is still not being consistently shared between agencies.

[326] NHS England Terms of Reference p1

14 Forensic assessment

14.1 30 December 2013: After Ian's Section 2 of the Mental Health Act 1983 was rescinded and he was discharged into the community, a discharge summary was sent to the GP. This letter commented that Ian was "dangerous when he [was] unwell"[327] and that a community forensic opinion was to be obtained in order to review Ian's accommodation and long-term treatment plan. There is no evidence that this occurred.

14.2 February 2016: AWP's SI report documented that the opinion of a forensic consultant psychiatrist was sought by the assessment and recovery service. This occurred at a liaison meeting, which was convened to discuss Ian's presenting risk factors and his future risk management.

14.3 The investigation team were informed by Milestones Trust staff that they had been invited to attend only the latter part of this meeting and therefore were not part of the discussion with the forensic consultant psychiatrist.

14.4 A record of this meeting was not documented in Ian's patient records, and the SI's authors reported that individual members of staff we spoke to during this investigation do not have a clear and consistent recollection of what was discussed and agreed.

14.5 The investigation team interviewed the forensic consultant psychiatrist, who confirmed that she did attend this meeting and that Ian was discussed. However, she did not make an entry in Ian's patient records or write to the assessment and recovery team outlining her thoughts and suggested actions.

14.6 As AWP's SI report identified, and as was evident from the chronology developed during the course of this investigation, it was clear that:

"The forensic opinion did not go on to inform the care, treatment and risk management of [Ian]."[328]

14.7 The lack of record-keeping of this meeting by AWP was highlighted in their SI report and was one of the recommendations that have been addressed in the subsequent action plan. This will be considered in further detail in section 4 of this report.

14.8 In order to understand the importance and challenges of undertaking longitudinal and ongoing risk assessments for patients such as Ian, who are known to present with both historical and current risks of harm to others, it is

[327] Discharge summary January 2014 p2

[328] AWP SI report p52

helpful to bear in mind the Royal College of Psychiatrists' guidance, which suggests that:

"The basis of all violence risk assessment is that past behaviour is the best guide to future behaviour. It follows that the most important part of risk assessment is a careful history of previous violent behaviour and the circumstances in which it occurred. On an individual level, a detailed understanding of the patient's mental state, life circumstances and thinking is a major contributor to the prevention of harm. … Risk management is a core function of all medical practitioners and some negative out-comes, including violence, can be avoided or reduced in frequency by sensible contingency planning … the risks posed by those with mental health problems are much less susceptible to prediction because of the multiplicity of and complex interrelation of actors underlying a person's behaviour."[329]

- The Royal College of Psychiatrists also advised that when there are concerns regarding a patient's risk of harm to others, this should:

"Trigger a more structured risk assessment process, with the use of an assessment tool that is appropriate for the group, such as an HCR-20[330] assessment … and avoiding the notion that one size fits all."[331]

14.9 Clearly, there were a number of options available to the assessment and recovery team:

- The team could have asked for an HCR-20 assessment [332]to be undertaken by a member of AWP's forensic team.

- Potentially Dangerous Person: consider the option of reporting Ian to the police as a Potentially Dangerous Person (PDP).[333] The Potentially Dangerous Person process targets people who are not managed under the three Multi-agency Public Protection Arrangements (MAPPA) categories[334]

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[329] Rethinking Risk p4

[330] Historical, Clinical Risk management-20 (HCR-20) is an assessment tool that helps mental health professionals estimate a person's probability of violence. HCR-20 is a comprehensive risk assessment tool that determines best treatment and management strategies for potentially violent, mentally disordered individuals. HCR-20 is a combination of statistical data with clinical information in a w ay that integrates historical variables, current crucial variables and contextual or environmental factors as well as an individual's forensic mental health. HCR 20 requires specific training. HCR-20

[331] Rethinking risk to others in mental health services

[332] HCR 20 is an assessment tool that helps mental health professionals estimate a person's probability of violence.HCR-20

[333] A PDP is a person who is not currently managed in one of the three multi-agency public protection arrangements (MAPPA) categories, but w hose behaviour gives reasonable grounds for believing that there is a present likelihood of them committing an offence or offences that will cause serious harm. PDP

[334] Multi-Agency Public Protection Arrangements (MAPPA) are the process through which the police, probation and prison services work together with other agencies to manage the risks posed by violent and sexual offenders living in the community in order to protect the public. MAPPA

but whose behaviour gives reasonable grounds for believing that there is a likelihood of them committing an offence or offences that could cause serious harm.

- The investigation team were of the opinion that given the concerns about Ian's risks to other vulnerable tenants, consideration should have been given by the assessment and recovery team to reporting Ian as a PDP, as he clearly met the following referral criteria for a PDP:

  "where a community psychiatric nurse (CPN) shares information with the police that a patient with mental ill health has disclosed fantasies about committing serious violent offences. The patient is not cooperating with the current treatment plan, and the CPN believes serious violent behaviour is imminent."[335].

  Such a course of action would have been helpful, because part of the police's responsibility is not only to develop an intelligence profile but also to coordinate a multi-agency risk assessment. Such an assessment would have included:

  "The nature and pattern of the individual's behaviour and risks.

  Who is at risk (e.g., particular individuals, children, vulnerable adults)?

  The circumstances likely to increase risk (for example, issues relating to mental health, medication, drugs, alcohol, housing, employment, relationships).

  Factors likely to reduce risk.

  Collect all relevant medical evidence that is available to consider whether there is a reasonable medical explanation for the behaviour displayed."[336]

- If accepted as a PDP, a risk management strategy is developed between the police and the other involved partner agencies, who work closely to share information, manage the ongoing risks and provide support to the PDP.

14.10 The investigation team would suggest that as a learning opportunity from this case, it would be helpful for AWP's assessment and recovery team to develop their understanding of PDP so that in future they have knowledge of this as an option that is available in the management of high-risk patients.

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[335] PDP
[336] PDP

Avon and Wiltshire Mental Health NHS Trust AWP)

Recommendation 9: Members of the assessment and recovery team should be provided with a continuous professional development session on the role and function of the police's Potentially Dangerous Person (PDP) scheme.

15 The involvement of Ian and his family in risk assessments

"Comment on the quality of involvement of the perpetrators family in the assessment and treatment of [Ian)."[337]

AWP

15.1 On 30 December 2015, it was documented in Ian's progress notes that he had given permission for information to be shared with his twin brother and sister-in-law, whom he was going to spend New Year with. However, no Consent to Share Information form was completed and there was no evidence that information was shared with them during the admission.

15.2 Ian's brother visited Ian twice while he was in AWP's inpatient unit, but there was no indication that the inpatient unit staff had any contact with him during these visits.

Cygnet Health Care inpatient unit

15.3 Ian's twin brother visited Ian on one occasion. He also collected Ian from the unit on the day of his discharge.

15.4 On one occasion (29 June 2016), a member of the inpatient unit spoke to Ian's twin brother, who reported that he:

"Was surprised by the tribunal decision, is concerned about him being discharged due to his recent presentation and would like his medication reviewed. Brother reported that clozapine was the most effective medication he had been on to date but understands that due to his physical health complications this was stopped."[338]

[337] NHS Terms of Reference p1

[338] Cygnet Health Care continuous written records 29 June 2016

Milestones Trust

15.5 It appeared that staff at Milestones Trust's supported housing scheme were aware of the involvement of Ian's brother, but there is no documented evidence of any interaction or discussions with Ian's brother.

Commentary and analysis

15.6 As Ian's twin brother has not engaged with this investigation, the investigation team have had to rely on information documented in AWP's SI report, which stated that he had reported during his interview with the authors that:

> "The only time he could recall being contacted in 2016 was by the AMHP on 13 June as part of the MHA[339] Assessment. He could not recall being contacted by any other mental health professionals during the period of care under review and has not been invited to any meetings about Patient A's care and treatment during 2016."[340]

15.7 AWP's SI report also reported that:

> "[Ian's] brother, who was regularly in contact with him, was not involved in planning his care or treatment and had very little contact from AWP mental health services. The Care Co-ordinator stated he had never spoken to [Ian's] brother."[341.]

15.8 This lack of communication was reflected in the evidence available to the investigation team, as there was no indication that members of Ian's family were asked to contribute to any of the Risk Summaries-point in time that were completed either by AWP's assessment and recovery team or during his last inpatient admission.

15.9 AWP's CPA and Risk policy outlines the importance of involving family in a patient's assessments and care plans. It states that:

> "An appropriate risk assessment will be completed based on the practitioner's assessment and risk scores in the Care Cluster Assessment, in conjunction with service users and their carer/family to address issues written in the care plan … Wherever possible carers will be consulted on and involved in all stages of developing care plans and reviewing the ongoing care of the service user, including the offer of a meeting alone to discuss any concerns .

[339] MHA Mental Health Act 1983 assessment
[340] AWP's SI report p59
[341] AWP's SI report p4

Wherever possible the care plan will be formed with the service user and carer."[342]

15.10 Despite there being one direct verbal communication between Ian's brother and a member of the ward staff, there was no evidence that he was invited to contribute to any of the assessments or recovery plans that were undertaken. This deficit was not highlighted in Cygnet Health Care's SI report.

15.11 Milestones Trust's failure to involve Ian's family was not highlighted in the report that they prepared for the SAR (October 2017).

15.12 With reference to the NHS ToR "Comment on the quality of involvement of the perpetrator's family in the assessment and treatment of [Ian]"[343], the investigation team have concluded that:

- Based on the evidence available, it is evident that all the involved agencies failed to involve Ian's family in his assessments and treatment both in the community and during his inpatient admission in 2016.

- There was no documented evidence that Ian's brother was offered any support or directed to the various carers' services within Bristol.

15.13 The investigation team would suggest that AWP's assessment and recovery team and its inpatient unit, Cygnet Health Care's inpatient unit, and Milestones Trust's supported housing scheme need to review their practice with reference to the following six key elements that are outlined in the Triangle of Care[344]:

- Carers and the essential role they play are identified at first contact or as soon as possible thereafter.

- Staff are 'carer aware' and trained in carer engagement strategies.

- Policy and practice protocols re confidentiality and sharing information are in place.

- Defined post(s) responsible for carers are in place.

- A carer introduction to the service is available, with a relevant range of information across the acute care pathway.

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[342] AWP's CPA and Risks policy p5 and p7

[343] NHS Terms of Reference p1

[344] The Triangle of Care offers key principles and resources to influence services and other people working with carers to be more effective in involving them within acute care. Triangle of Care is a therapeutic alliance between service user, staff member and carer that promotes safety, supports recovery and sustains well-being. Triangle of Care

- A range of carer support services is available.

In addition to the above, there needs to be regular assessing and auditing to ensure these six key elements of carer engagement exist and remain in place.[345]

Cygnet Health Care, Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) and Milestones Trust

Recommendation 10: Cygnet Health Cares, AWP's inpatient unit, and Milestones Trust should review their practice with reference to the Triangle of Care's six key elements of carer engagement.

16 Care planning

"Examine the effectiveness of the service user's care plan including the involvement of the service user and the family, specifically in relation to risk assessment/risk of violence and effectiveness of CPA review."[346]

AWP

16.1 4 June 2012: Ian's care plan was reviewed by his care coordinator from the assessment and recovery team. The plan focused on the following recovery goals: managing mental health, medication and his physical health. It documented his relapse indicators, a contingency plan with details of out-of-hours services and Ian's views. It was also documented that Ian's GP provided input, but there was no evidence that staff from Milestones Trust's supported housing scheme were invited to contribute to the review.

16.2 5 March 2013: Ian's care plan was reviewed again. The following support needs and crisis plan were identified:

- Physical health: monitor Ian's high cholesterol levels with a combination of medication and blood tests at his GP surgery.

- Maintaining independent living skills: identified his daily living skills/routine – shopping, maintaining his flat.

- Maintaining contact with Ian's family and having a "good relationship with staff and other tenants … [Ian reported] that he was friendly with most of the residents."[347]

[345] Triangle of Care p5
[346] NHS England's Terms of Reference p1
[347] 5 March 2013 Care Plan updated p2

- Continuing to meet with staff at the supported housing scheme.

- Again, it was documented that the GP had been involved but not Milestones Trust's supported housing staff.

- This document indicated that it was distributed on 18 December 2013 to Ian, the responsible medical officer ("RMO"[348]), the community psychiatric nurse (CPN) and the occupational therapist ("OT"[349]).

16.3 5 March 2014: At a CPA review, Ian's care plan was reviewed. The following areas were identified:

- Risks to others at the supported housing scheme when Ian was unwell or intoxicated. Ian to approach support staff if he felt any symptoms or a decline in his mental health. Support staff would ask Ian about his thoughts and feelings with regard to harming others.

- Physical health monitoring: to have yearly physical health checks at the GP.

There were also two entries relating to Ian's alcohol consumption:

- Ian to refrain from being verbally abusive towards other tenants when he had been drinking and "to curtail his drinking and explore other accommodation with higher support"[350].

16.4 There was an additional entry on the care plan dated 16 March 2015: Clozapine monitoring – Ian agreed that he would receive weekly monitoring visits from his care coordinator and that he would report any adverse mental health and behavioural symptoms to his GP and members of the supported housing staff.

16.5 There was no indication that either the care plan dated March 2014 or the additional entry in March 2015 was distributed to any involved agencies.

16.6 There were no other care plans completed in AWP's care planning format from March 2015, although it was evident that practitioners were using Ian's patient records to document care plans.

Cygnet Health Care

16.7 On admission to Cygnet Health Care's inpatient unit, a care plan was completed. This included a 'physically health' plan.

[348] Responsible Medical Officer (RMO): the RMO is appointed by the hospital managers when a patient is detained under the Mental Health Act in that hospital

[349] CPA document 18 December 2013

[350] AWP Care Plan December 2013 p3

16.8 The staff updated Ian's care plan six times during his admission. The focus of the original and updated care plans was on Ian's inpatient admission.

16.9 There was no indication that the involved AWP services, Ian's GP or Milestones Trust's supported housing staff were asked to contribute to Ian's care plans.

Milestones Trust

16.10 There was no evidence made available to Sancus Solutions' investigation team that the supported housing scheme were using a formal care planning assessment pro forma but they do utilise the Recovery Star in order to identify and consider a tenants' aspirations and goals.

16.11 Information on Ian's support needs etc. appears to have been also documented within the diary entries that were completed by support workers.

Commentary and analysis

16.12 AWP's CPA and Risk Assessment policy stated that:

"All service users allocated to CPA will have a comprehensive care plan, which must be agreed at the meeting. It is the care co-ordinator's responsibility for maintaining this care plan (though not delivering it all)."[351]

The investigation team would suggest that the evidence indicates that once Ian's recovery navigator became involved, the care coordinator did not maintain an overview of the care plans, even when it was evident that Ian's mental health risks were significantly escalating. Nor was the care coordinator ensuring that Ian's care plans and Risk Summary –point in time were being completed in compliance with AWP's CPA and Risk policy

16.13 The authors of AWP's SI report concluded that:

"Care plans were in place but these were basic and focussed primarily on [Ian's] need to accept his antipsychotic medication. There were no care plans to address other known problems such as alcohol misuse and the difficulties he intermittently experienced with other residents at his accommodation. There is no evidence of [Ian] being an active participant in the formulation of his care plans and the views of his accommodation provider and family (brother) are not captured."[352]

The investigation team concur with this observation.

[351] AWP CPA and Risk policy pp5, 6 and 7
[352] AWP's SI report p25

16.14 However, neither AWP's nor Cygnet Health Care's SI report highlighted the lack of involvement of Ian's family and Milestones Trust in the development of Ian's care plans.

16.15 It was also noticeable that Cygnet Health Care's report did not make any reference to the fact that their inpatient unit did not invite Ian's care coordinator or AWP's inpatient unit to contribute to their care plans.

16.16 It is also concerning to the investigation team that none of the involved agencies who knew that Ian was to be discharged on 7 July 2016 completed a discharge care plan.

17 Care Coordinator

17.1 AWP's SI and SAR reports both highlighted the reasons why the care coordinator did not maintain an overview of Ian during his inpatient admission or coordinate an adequate discharge plan until the day of Ian's discharge.

17.2 AWP's SI report document cited the following contributory factors:

- "Care Coordinator was under the misconception that Patient A would not be discharged directly from [Cygnet Health Care inpatient unit] into the community but would be returning to an AWP bed first."[353]

- "Care Coordinator is also a Trade Union (TU) representative and has responsibilities in addition to those assigned to him as part of his employment by the Trust as a mental health nurse and Care Coordinator.

- AWP's Trade Union Facilities and Partnership Working Agreement state TU representatives should complete an electronic form to be submitted to their manager to evidence the TU work they're completing. This allows the manager to have oversight of the amount of additional work the TU member is involved in and can then make an informed decision with regard to making reasonable adjustments to the clinical workload. In this case, the Care Coordinator had fallen out of the practice of completing these electronic forms routinely, and as a consequence, his manager did not have a record of how much TU work he was completing alongside his clinical responsibilities."[354]

17.3 AWP's SI recommendations have addressed these deficits at individual competency, managerial and organisational levels, to ensure that TU responsibilities do not impact on clinical responsibilities. As the investigation team are satisfied that this issue has been addressed, they do not intend to make any further comment.

[353] AWP SI report p4
[354] AWP SI report p48

18 Record keeping

"Review the documentation and record keeping of key information by the Avon and Wiltshire Partnership NHS Foundation Trust, Cygnet Health Care against its own policies, best practice and national standards."[355]

18.1 The investigation team reviewed the record-keeping of both AWP and Cygnet Health Care's inpatient unit and concluded the following:

AWP

- From 2013 all of AWP's patient records were electronic and used the RiO patient records system. This is a system that is used in many mental health NHS trusts throughout England.

- Ian's historic records were archived[356] in paper format and had not been uploaded when RiO was introduced. Practitioners from the assessment and recovery team reported that they had not been aware that such records existed. The investigation team suggest that as Ian was a patient who had an extensive forensic risk history, it would have been helpful for one of the involved clinicians to have undertaken a review of his historic archived records in order to obtain a fuller risk history that could have informed their risk assessments.

- The investigation team were able to track all the events that involved and the decisions that were taken by both the assessment and recovery team and the inpatient unit.

- The investigation team concluded that Ian's AWP records were generally comprehensive in content, and the information documented was accessible.

- AWP had a clear and comprehensive Health and Social Care's Records policy, which stated that:

  "High quality records support effective clinical judgements, allow easier continuity of care, identify risk and enable early detection of complications, provide documentary evidence of service delivered, promote better communication and sharing of information between members of the multi-professional healthcare team, support patient care and communications and support the delivery of services."[357]

- The policy was comprehensive with regard to practitioners' responsibilities, training and security; confidentiality of personal and sensitive data; and archiving of information. It also provided a number of hyperlinks to other

[355] NHS England Terms of Reference p2

[356] Sancus Solutions' investigation team accessed and reviewed all of AWP's archived records for Ian

[357] AWP's Health and Social Care Records Policy p3

relevant AWP policies, such as risk assessments and best practice guidelines.

Cygnet Health Care inpatient unit

- All of Cygnet Health Care's records and assessments – apart from the continuous written records, which were handwritten – were also electronic.

- The investigation team found that the continuous written records were, at times, difficult to read due to the poor quality of some of the handwritten entries. This resulted in difficulty in accessing important information promptly and is likely to have been an issue for the ward staff.

- The investigation team would suggest that Cygnet Health Care looks at the viability of introducing electronic ward records.

Cygnet Health Care

Recommendation 11: Cygnet Health Care should consider the viability of introducing electronic continuous records in their inpatient units.

18.2 With reference to the NHS ToR "Review the documentation and record keeping of key information by the Avon and Wiltshire Partnership NHS Foundation Trust, Cygnet Health Care against its own policies, best practice and national standards"[358], The investigation team have concluded that the evidence indicates that:

- In the main, both AWP's and Cygnet Health Care's inpatient unit's patient records were of a good standard and compliant with their agencies' policies and best practice guidelines.

19 Discharge planning

"Review the quality of discharge planning between community services, inpatient services and the housing provider."[359]

19.1 Following the Mental Health Tribunal (28 June 2016), a CPA meeting was not arranged. The care coordinator reported that it was his expectation that Ian would be transferred to AWP's inpatient unit prior to discharge and that a CPA review would occur.

[358] NHS England Terms of Reference p2
[359] NHS England Terms of Reference p2

19.2 As has already been identified, the care coordinator and Cygnet Health Care's inpatient unit did not discuss Ian's discharge plans until the day of his discharge.

19.3 Milestones Trust's staff was also unaware that Ian had been transferred to Cygnet Health Care's inpatient unit and that his Mental Health Act section had been rescinded with a deferred discharge date agreed.

19.4 As the chronology indicated, there was no communication between Ian's care coordinator, the inpatient staff and Milestones Trust until the day of Ian's discharge.

19.5 Cygnet Health Care's inpatient staff were in agreement that Ian was not exhibiting behaviours that warranted further detention under the Mental Health Act 1983. Also, Ian refused the suggestion that he should become an informal patient.

19.6 As there had been no communication between Ian's care c coordinator, Cygnet Health Care's inpatient unit and the supported housing team until the day of Ian's planned discharge, it was not known that eviction proceedings were going to be actioned by UCHA but that this would take some time.

19.7 It was not until the day of Ian's discharge that the care coordinator arranged for BCS to support Ian, but this would not commence until the following day (7 July 2016).

19.8 As Ian was not discharged until 4pm, by the time his brother left him at the supported housing scheme no Milestones Trust staff members were present at the accommodation.

Commentary and analysis

19.9 It is clearly evident that Ian's discharge was poorly managed and was a significant contributory factor to Ian being discharged into the community with no support and no care plan or risk assessment undertaken. The evidence indicates that there was a combination of reasons why this occurred:

- AWP's bed manager, who usually attended ward rounds at Cygnet Health Care's inpatient unit, was on holiday, and there were, at the time, no arrangements in place to cover this situation. The investigation team were informed that this has now been addressed. This issue and will be discussed further in section 4.

- No one from AWP attended the two ward rounds that occurred after Ian's Mental Health Tribunal.

- There was no liaison, either prior to the Mental Health Tribunal or prior to Ian's discharge date, between the consultant psychiatric teams of Cygnet Health Care and AWP to discuss discharge treatment plans – for example, whether Ian's clozapine should be restarted.

- Neither AWP's care coordinator nor Milestones Trust contacted Cygnet Health Care's inpatient unit until the day of Ian's discharge; therefore, significant information regarding Ian's risks of harm to others and Milestones Trust's intention to seek eviction were notcommunicated.

- Additionally, as Milestones Trust did not make contact with Ian's care coordinator, they were unaware of the date that Ian was to be discharged; therefore, they were not able to instruct UCHA to action emergency eviction procedures until the day of his discharge. Ian therefore had a legal right to return to his accommodation.

19.10 The investigation team were informed that:

- It is usual practice that when an AWP patient is in an out-of-area hospital, they return to an AWP inpatient unit before discharge planning is actioned; at this point, their risk assessment and support plan will be reviewed. The investigation team would suggest that as the care coordinator attended the Mental Health Tribunal, he was aware of the deferred discharge that was agreed by the Mental Health Tribunal panel so that discharge planning could occur. Therefore, the care coordinator had ample opportunity to have liaised with the bed management team to discuss the arrangements for Ian's return to an AWP inpatient unit.

- AWP's bed management team reported to both the investigation team and the authors of AWP's SI investigation that at the time of this incident, it was common practice that when they were unable to attend an out-of-area ward round that a member of the patient's community mental health team would attend. However, the care coordinator reported that he had not been aware that the bed manager was on holiday. Actions that have been taken since this incident will be highlighted in section 4.

19.11 At the time of this incident, AWP had a contract with Cygnet Health Care that block-funded a number of beds in the local Cygnet Health Care hospital for AWP patients. This contract detailed both the purchasing agreement and a joint operational protocol for the management of AWP's patients. At the time of Ian's admission, this contract outlined that there should be a multi- disciplinary meeting (hereafter referred to as MDT) seven days after an AWP patient's admission. There was evidence that several MDT meetings took place during Ian's admission that only Cygnet Health Care practitioners

attended. There was no indication that the involved AWP or Milestones Trust practitioners were invited to attend.

19.12 Improvements that were required were identified in both Cygnet Health Care and AWP's SI reports, and recommendations were made to improve interagency communication and discharge planning. The service contract between the two agencies has also been revised. Progress on implementing these improvements will be discussed further in section 4 of this report.

19.13 With reference to the NHS ToR "Review the quality of discharge planning between community services, inpatient services and the housing provider"[360], the investigation team have concluded that:

- The evidence clearly indicates that the discharge planning between all the involved agencies was extremely poor and resulted in Ian being discharged with no robust discharge risk assessments, care planning or housing management in place. Therefore, Ian had a legal right to return to his accommodation with no adequate support in place, despite a recent history of risk of harm to other vulnerable tenants.

20 Mental Health Tribunal

"Comment on the processes of mental health act tribunals when Service users are transferred between services and providers mid-application.

Review the decision making of the Mental Health Review Tribunal, commenting on the quality of information provided to that group."[361]

20.1 10 June 2016: Due to increasing concerns regarding Ian's mental health and his potential risk to others, the assessment and recovery consultant psychiatrist requested a Mental Health Act 1983 assessment. Due to a lack of bed availability, the assessment did not occur for two days.

20.2 During this time, there was ongoing communication between BCS, AWP's on-call bed management team and the EDT team (see section 2 for details), and several unsuccessful referrals were made to out-of-area private hospitals.

20.3 Over the weekend period, a difference of opinion developed between the EDT and BCS with regard to the ongoing delay in the Mental Health Act 1983 assessment being undertaken. EDT refused to undertake the assessment until an inpatient bed was allocated. This resulted in a complaint being lodged by a member of the BCS team to her senior managers.

[360] NHS England Terms of Reference p2
[361] NHS England Terms of Reference p1-2

20.4 13 June 2016: Following new evidence, in the form of written threats made by Ian and CCTV evidence of significant sexualised behaviour at the supported housing scheme, Ian was arrested. A Mental Health Act 1983 assessment was undertaken at the police custody unit, and Ian was detained under a Section 2 of the Mental Health Act 1983 and subsequently transferred to AWP's PICU inpatient unit.

20.5 As part of the assessment, the AMHP contacted Ian's twin brother, and his views were incorporated into the assessment report. This report was included within Cygnet Health Care's patient records, so it can be assumed that it was part of the information when Ian was transferred to Cygnet Health Care's PICU. Therefore, a considerable amount of background information about Ian was available to inform the reports submitted to the Mental Health Tribunal.

20.6 14 June 2016: Ian was given information regarding his right to appeal his against his detention, and he indicated that was his intention.

20.7 20 June 2016: Ian was transferred to Cygnet Health Care's PICU ward. Ian was given a Section 2 patient information leaflet, and on 23 June 2016 Ian applied to the Mental Health Tribunal to appeal against his Section 2 of the Mental Health Act 1983.

20.8 27 June 2016: The care coordinator received notification that Ian's Mental Health Tribunal hearing was due to take place the following day at Cygnet Health Care Hospital. He then contacted the ward to obtain information about Ian's admission.

20.9 28 June 2016: A First tier (Health, Education and Social Care Chamber) Mental Health Tribunal was convened.

20.10 Ian had legal representation and was interviewed by the medical member of the tribunal panel prior to the hearing.

Reports submitted to the First tier (Health, Education and Social Care Chamber) Mental Health Tribunal

Cygnet Health Care's PICU consultant psychiatrist, a member of the nursing staff and Ian's AWP care coordinator submitted written reports, and all attended the Mental Health Tribunal.

AWP's care coordinator's social circumstances report:

20.11 In the section 'Details of any index offences and other relevant forensic history', the care coordinator had copied sections from Ian's AWP patient records. These included:

- Ian's forensic history from 1987, including the various incidents (from 5 October 2013 to 10 June 2016) of aggressive/violent and sexually disinhibited behaviours towards other tenants. One incident, on 15 December 2013, was noted as "an unprovoked attack"[362]. Kamil and his ethnicity were identified as being one of the victims, and it was noted that "query racially driven attack – in the context of paranoid ideation". The last incident was 13 June 2016, while Ian was in police custody, when he made a reference to 14-year-old girls and paedophilia and the concern regarding Ian's possible "risks to children and young people"[363].

- The report also provided a chronology of Ian's historic mental health history and symptomology, as well as the events that led up to his recent inpatient admission. It documented the two incidents when Ian had committed serious assaults on members of nurse staff. It also provided evidence of Ian's historic and current alcohol and substance misuse and commented that both were contributory factors in the deterioration in Ian's mental ill health. The report also provided details of his clozapine history.

- Details of Ian's family history and the current issues with regard to his accommodation were also documented. The care coordinator reported:

  "I understand that [Ian] is likely to be evicted because of potential risks/safeguarding issues that presented before this admission. A referral for a Social Care Assessment has been made and he will be eligible for a Community Care Package under Section 117 of the Mental Health Act."[364]

- In response to the question "So far as is known, details of the care pathway and Section 117 after care to be made available to the patient together with details of the proposed care plan"[365], the care coordinator documented that "this will need to be carefully planned now his placement at Aspects and Milestone Trust [sic] is untenable"[366].

- The care coordinator documented that "potentially [Ian's] risks could be managed through the MAPPA process"[367].

- The care coordinator documented that due to the short time frame he was given to prepare his report, he had been unable to obtain information from either Cygnet Health Care's inpatient unit or Ian's family. Although there was evidence that he contacted Milestone Trust on 27 June 2016 to obtain an update on Ian's tenancy status.

[362] Care Coordinator's Social Circumstances Report 23 June 2016 p2
[363] Care Coordinator's Social Circumstances Report 23 June 2016 p2
[364] Care Coordinator's Social Circumstances Report 23 June 2016 p5
[365] Care Coordinator's Social Circumstances Report 23 June 2016 p5
[366] Care Coordinator's Social Circumstances Report 23 June 2016 p5
[367] Care Coordinator's Social Circumstances Report 23 June 2016 p6

- The care coordinator concluded that there was "evidence that in the interests of the patient's health and safety [and] for the protection of others detention under the Mental Health Act remains necessary … It is quite likely that [Ian] will remain a risk to others and this risk is constant."[368]

- In response to the question "whether and if so how, any risk could be managed effectively in the community", the care coordinator stated: "the risk will be managed by a very tight contingency plan"[369].

- The contact details of the recovery navigator, the consultant psychiatrist, the crisis service and Milestones Trust were documented, as well as a copy of part of Ian's risk assessment undertaken by BCS.

Cygnet Health Care's consultant psychiatrist's report

20.12 The introduction section of this report indicated that Cygnet Health Care's consultant psychiatrist had reviewed the psychiatric assessments and recommendations from the Mental Health Act 1983 assessment. It provided details of what led up to this assessment and a brief history of Ian's mental health and offending behaviours. That included "threats to kill"[370].

20.13 The report documented details of Ian's family and also his recent adverse reaction to clozapine.

20.14 It was also documented that "it [was] not clear to us why he was transferred from [AWP's] PICU to us. Maybe because of his sexual disinhibited behaviours and thus there may have been some adult safeguarding issues."[371] The investigation team would suggest that this information could easily have been obtained from AWP.

20.15 The report provided details of Ian's presentation since his arrival on the unit, including his initial and ongoing mental state assessments. It was also noted that Ian had a history of alcohol and substance misuse.

20.16 The consultant psychiatrist concluded that Ian:

"was neither hostile nor agitated. I felt he was ready to be stepped down to an ordinary acute facility, hence asked for him to be referred back to such a unit in Bristol. In the meantime, as I felt that his risks were diminishing, I granted escorted leave in the hospital grounds … and consider that currently his symptoms no longer reach the threshold for degree in recognition of

[368] Care Coordinator's Social Circumstances Report 23 June 2016 p7
[369] Care Coordinator's Social Circumstances Report 23 June 2016 p7
[370] Cygnet Health Care's psychiatric report 23 June 2016 p1
[371] Cygnet Health Care's psychiatric report 23 June 2016 p2

significant recent improvements. I believe detention would be in the interests of his health and safety and for the protection of others."[372]

The consultant psychiatrist recommended that Ian's Section 2 should remain"[373]

Decision made by First tier (Health, Education and Social Care Chamber) Mental Health Tribunal

20.17 The Mental Health Tribunal Report was very detailed, documenting:

- Ian's mental health and forensic histories, his mental health diagnosis , his positive and adverse reactions to medication, and the events that led up to his recent admission.

- With regard to any future substance and alcohol misuse, it was noted that Ian showed considerable insight into the events that led up to this recent admission in the context of his alcohol and substance misuse. The panel concluded that because of the "distressing and intensive symptoms that [Ian] experienced as a result of his binge there [was] a real disincentive for him to repeat that action particularly that his sleep [has] improved with the help of medication"[374].

- It was stated that the argument presented by the consultant psychiatrist "relied upon the nature of the disorder rather than the degree[375] … [the] chronicity of the illness, its historic high risk profile and in particular the very risky behaviour at the patient's accommodation prior to the admission."[376]

- The consultant psychiatrist indicated that in his opinion, it was in Ian's best interest to be transferred back to AWP's inpatient unit prior to discharge. The tribunal panel concluded that they were satisfied that Ian had a mental disorder but that he was currently presenting as asymptomatic. Therefore, they could not see the benefits in any further inpatient assessments or treatments that could not be undertaken in the community.

- It was also documented that both the care coordinator and the consultant psychiatrist had been persuasive in their argument that a robust discharge

[372] Cygnet Health Care's psychiatric report 23 June 2016 p3
[373] Cygnet Health Care's psychiatric report 23 June 2016 p3
[374] First-tier Tribunal report 28 June 2016 p4
[375] Nature and/or degree: the test requires that appropriate treatment is actually available for the patient. It is not enough that appropriate treatment exists in theory for the patient's condition. Case law has established that "nature" refers to the particular mental disorder from which the patient is suffering, its chronicity, its prognosis, and the patient's previous response to receiving treatment for the disorder. "Degree" refers to the current manifestation of the patient's disorder. Nature and degree
[376] First-tier Tribunal report 28 June 2016 p4

care plan needed to be agreed with all involved community agencies prior to Ian's discharge. Also, as it was unlikely that Ian would remain in hospital on an informal basis; therefore, the tribunal panel made the decision to defer Ian's section discharge "for a period to allow for further discharge planning"[377].

- The date set by the First-tier Tribunal for Ian's discharge was 6 July 2016 at 4pm.

Commentary and analysis

20.18 AWP's SI report concluded that the care coordinator's reports "could have been more comprehensive and should have included information about [Ian's] threats to kill and arrest"[378]. The investigation team do not agree with this comment, as, in their view, the care coordinator's report contains both details of Ian's historic forensic history and information regarding the assaults on other tenants, including Kamil, from 2013 to his arrest on 10 June 2016.

20.19 Given the fact that the care coordinator was given less than 24 hours to produce his Social Circumstances report the investigation team would suggest that it is as comprehensive as it could have been. That being said, it would have been helpful if the opinions of Milestones Trust had been sought by AWP's care coordinator in order to inform his report, especially with regard to obtaining up-to-date housing management information.

20.20 With regard to the report submitted by Cygnet Health Care's consultant psychiatrist, the investigation team again concluded that the report was comprehensive. It clearly documented the nature and degree of Ian's disorder and the challenges that they faced in the treatment of him.

20.21 Again, it would have been useful if Cygnet Health Care's consultant psychiatrist had made efforts to obtain further information regarding Ian's psychiatric history and recent presentation from AWP's inpatient unit and/or the assessment and recovery consultant psychiatrists in order to inform both his report and his presentation to the tribunal panel.

20.22 With regard to the following NHS England terms of reference:

"Comment on the processes of mental health act tribunals when Service users are transferred between services and providers mid-application.

Review the decision making of the Mental Health Review Tribunal, commenting on the quality of information provided to that group."[379]

[377] First-tier Tribunal report 28 June 2016 p5
[378] AWP's SI report p4
[379] NHS England Terms of Reference p1-2

The investigation team have concluded that:

- Information provided by AWP's care coordinator and Cygnet Health Care was, given the limited time available, fairly detailed, but both failed to obtain information from the other involved agencies.

- Based on the evidence that was available to the First-tier Tribunal, their decision to discharge Ian's Section 2 of the Mental Health Act 1983, with a deferred date, was proportionate.

- The investigation team would suggest that the fundamental problems were that there was no evidence of any discharge planning taking place, and Milestones Trust were not informed of the First-tier Tribunal's decision to discharge Ian's section. They had not proceeded with any eviction action when Ian was initially admitted to hospital; therefore, the housing management actions that were available to them on the day of Ian's discharge were very limited. Additionally, there was also no discharge risk assessment or care planning undertaken by either AWP or Cygnet Health Care's inpatient unit.

21 Housing management

This section will consider the housing management challenges that Milestones Trust were having to negotiate with regard to the ongoing issues within the service, specifically in relation to Ian's risk of harm to other tenants, including Kamil.

It will also comment on Kamil's family's request that the investigation should:

"Review and assess the quality of all clinical risk assessment to determine if [Ian] posed specific risks to the victim based on their ethnicity, gender, race, religion or culture. If risks of this nature were identified they were formulated as potential Hate Crimes and were appropriate steps taken to mitigate/address those risks"[380]

21.1 Prior to moving into the supported housing scheme (2010), Ian had been living in one of Milestones Trust's CQC registered care homes. This service provided 24-hour care and support to adults with mental health difficulties. During this placement, there were no reported incidents with regard to Ian's mental health or his tenancy.

21.2 Ian was then referred to one of Milestones Trust's supported housing schemes (2 June 2010). The referral was made by his local authority social worker, who had assessed that Ian needed "support to maintain his recovery

[380] NHS England Terms of Reference p2

as he [was] moving from significant institutional care to aspiring to be more independent and competent in all areas of daily living"[381].

21.3 Milestones Trust's supported housing scheme consisted of nine self-contained flats and bedsits and some communal living areas, which includes a tenants' lounge, laundry facilities and a small staff office.

21.4 Support provided to tenants at the scheme was at the time funded by Bristol Supporting People.[382]. Rent is funded through housing benefit, in some cases a proportion of the rent is paid by the tenant. Funding is not for the provision of personal care or support that is being provided by statutory services, such as mental health support.

21.5 The aim of the service is to provide tenants with mental health issues with housing-related support in order to maintain their tenancies. The support offered is focused on developing agreed independent living skills with the aim of the tenant progressing to permanent accommodation, either in the social or private housing sectors. Support plans, which identify specific outcomes and goals, are agreed with the tenant and any other involved agencies.

21.6 Tenants are allocated a lead support worker but may also be seen by other support staff. Although there is a staff office at the property the service is not funded to maintain a staff continual presence on site. Support worker only visit the scheme for a limited number of hours as dictated by the individual tenants' funding arrangements.

21.7 When Ian initially moved into his accommodation, he was in receipt of support for six hours a week. In April 2012 Ian's support was reduced to five hours and his support plan included support to maintain his physical health, for example with shopping, cooking and completing forms.

21.8 In March 2015 Milestones Trust and UCHA entered into a management arrangement. Under this arrangement, tenants would be issued with a Milestones Trust's Short Assured tenancy agreements, UCHA would provide tenancy advice, and on the instruction of Milestones Trust they would action eviction proceedings in respect of a breach of a tenancy agreement – for example, antisocial behaviours and rent arrears.

[381] Milestones Trust's report for the SAR p3

[382] The Bristol Supporting People (SP) programme offers a range of housing-related services to help a person live independently. SP work in partnership with organisations to offer support so a person can either remain in their own home or move to a new one. Bristol Supporting People

21.9 As Ian's placement was prior to this agreement with UCHA. Milestones Trust had issued him with an Assured Tenancy Agreement.[383]

22 Incidents involving Ian and other tenants

22.1 2013

- Not long after Kamil moved into the service (January 2013), there began to be a number of concerning incidents involving Ian and Kamil. These included:

- 22 June 2013: Ian set off the fire alarm in the housing scheme and then attempted to enter Kamil's accommodation. Ian was under the influence of alcohol at the time. It was documented that Kamil reported that he was upset, as Ian had refused to take his shoes off before he entered Kamil's accommodation. It was documented that in doing so Ian had shown a disregard for Kamil's cultural and religious practices.

- 5 August 2013: Kamil cut the TV cable in the communal lounge. Initially Kamil refused to pay for the repairs and a letter was sent to him outlining that the damage to the scheme's property was in breach of his tenancy agreement. Kamil then agreed to a payment schedule for the repairs.

- September 2013: Ian's clozapine had to be stopped due to a "red alert" blood result.[384]

- 5 October 2013: Ian punched Kamil a number of times and Kamil sustained bruising around his eye. The police were called, but Kamil did not wish to pursue a prosecution and Ian received a police caution[385]. Ian was issued with a formal warning by Milestones Trust that the incident was in breach of his tenancy agreement, which stipulated that tenants were "Not to be a nuisance to other people living in the property … [and were] not to use threatening or violent behaviour to other tenants"[386]. It was also noted in the letter that Kamil had stated that Ian had "verbally racially abused him"[387]. Ian later apologised for the racist language, stating that he had used it in the heat of the moment.

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[383] Assured Tenancy Agreement: The main difference is that when a landlord has let their property under a Short-Assured Tenancy (AST), they have an automatic right to regain possession of it at any time after the fixed term of the tenancy agreement has expired, provided sufficient notice is given to the tenant. Landlords who have let their property using an Assured Tenancy agreement do not have this right, as the tenant has security of tenure. Landlords who have issued an Assured Tenancy Agreement must instead wait until particular limited circumstances have occurred that give them grounds to seek a possession order against the tenants (such as the tenants being in rent arrears). Tenancy Agreements

[384] Milestones Trust notes indicated that within a few days, Ian's behaviour and presentation changed

[385] Police recorded this incident as a racially aggravated common assault

[386] Milestones Trust first formal written warning to Ian 23 October 2013 [387]

Milestones Trust first formal written warning to Ian 23 October 2013

- 29-30 October 2013: Ian was verbally sexually inappropriate with a member of Milestones Trust and AWP support workers.

- 10 November 2013: Ian was sexually inappropriate with a female tenant and her daughter.

- 13 November 2013: Ian informed a Milestones Trust support worker that he intended to physically harm a female tenant's boyfriend, as he would not let Ian into the flat and owed him money.

- 16 December 2013: Ian was verbally racially abusive and punched Kamil in the face, in what was reported as being an unprovoked attack. Ian was subsequently arrested by the police and a Mental Health Act 1983 assessment was undertaken while Ian was in police custody. Kamil reported that this incident was racially motivated.

- December 2013: Milestones Trust issued Ian with his second written warning, citing that he was "both verbally and racially abusive to [Kamil] and then you physically assaulted [Kamil] causing him injury"[388]. Ian was advised that he was in serious breach of his tenancy and that any further incident "could put [his] tenancy at risk"[389]. The letter cited that this incident had a possible "racially-driven motive"[390] and that the police "will need to consider whether it is appropriate for you to return"[391] to the scheme.

- The discharge summary (28 January 2014) noted that Ian reported that he did not get on with Kamil and had "racist feelings towards him"[392].

22.2 2014

- On 2 January 2014 it was documented in Ian's progress notes that the supported housing scheme had reported that they had been unaware that Ian was being granted Section 17 leave[393] and that they were concerned that Ian had returned intoxicated to the scheme over the New Year. They had also reported that Kamil had now returned to the scheme after the Christmas break and that he had previously threatened "to stab"[394] Ian if Ian returned to the service. There were concerns due to the lack of staff presence at the scheme during the evenings and at weekends to monitor Ian's visits. It was also documented that Kamil reported to the scheme's manager that he was

[388] Milestones Trust second written warning to Ian 20 December 2013
[389] Letter from Milestones Trust 20 December 2013
[390] Milestones Trust second written warning to Ian 20 December 2013 p2
[391] Milestones Trust second written warning to Ian 20 December 2013 p2
[392] AWP discharge summary 28 January 2014
[393] Section 17 of the Mental Health Act (1983) allows the Responsible Clinician (RC) to grant a detained patient leave of absence from hospital. Section 17 leave
[394] Progress notes 2 January 2014

"frightened of [Ian] returning"[395]. The police had previously advised that Kamil should contact the police using the 999 number, as the property had been marked as requiring their immediate response.

- 7 January 2014: Ian was interviewed by the police and admitted to assaulting Kamil. The police concluded that no further action was to be taken. The ward informed the supported housing scheme's manager of the decision and that Ian wished to return to his accommodation. It was documented that the manager expressed her concerns about Ian returning, as there had been a disclosure by a female tenant that Ian had been sexually inappropriate.

- 8 January 2014: Milestones Trust issued Ian with his third and final written warning, citing an incident where he was sexually inappropriate with a female tenant prior to his admission to the inpatient unit (the incident occurred on 12 November 2013). The letter concluded that "any further incidents [would] lead to the end of [Ian's] tenancy"[396].

- 15 January 2014: An application was made for an interim injunction to prevent Ian from returning to the supported housing scheme. Ian did not attend, and the court was unwilling to issue an injunction without Ian being present. The hearing was adjourned. Ian returned to his accommodation.

- 31 January 2014: A safeguarding meeting took place between Milestones Trust, the police, Bristol City Council (BCC) Adult Social Care and Support Services, and the care coordinator to discuss the dynamics between Ian, Kamil and another female resident.

- 21 March 2014: Ian entered a female tenant's accommodation uninvited and reportedly had asked her to perform oral sex. It was documented that Ian's alcohol consumption was increasing and that this incident occurred when he was intoxicated. A safeguarding referral was made.

- 1 April 2014: The supported housing manager emailed Ian's care coordinator to report that the following incident had occurred in the supported housing scheme. On 30 March Ian had knocked on a tenant's door and asked if he could come in "to calm down as he was going to hit"[397] Kamil. He also disclosed that "something is going to happen to [Kamil] like accident/hit by a car"[398]. The tenants at the scheme were also reporting that Ian was intoxicated most weekends.

[395] AWP progress notes 7 January 2014

[396] Milestones Trust final written warning to Ian 8 January 2014 p1

[397] AWP progress notes 1 March 2014 email from supported housing manager

[398] AWP progress notes 1 March 2014 email from supported housing manager

- 2 April 2014: The care coordinator challenged Ian about the incident with the female tenant. It was documented that Ian "made light of this saying it's only a bit of fun they ought to be able to take a bit of banter"[399]. The care coordinator arranged for Ian to be reviewed by his consultant psychiatrist, and also arranged to see Ian with the supported housing scheme's manager the following week.

- 22 October 2014: Supported housing staff were informed by Kamil's social worker that he had told her that he was carrying a Stanley knife and would use it if he felt threatened by Ian. A safeguarding referral was made. The knife was removed from Kamil, and Ian and his social worker were advised of this potential threat.

22.3 2015

- November 2015: Ian had to again stop taking clozapine due to adverse blood results.

- 10 December 2015: The recovery navigator and the supported housing staff agreed that due to the potential risks, Ian would only be seen in the communal areas. During a meeting with the consultant psychiatrist, it was documented that Ian had "strongly denied any sense of aggressive behaviour or that he had a problem with Kamil … however he did go onto talk about Kamil and some issues that he had with him."[400]

- 12 December 2015: Two members of BCS visited Ian in order to undertake an assessment. The following was documented:

  "Risk to others: when asked about his relationship with other residents in [the] supported accommodation [Ian] made particular reference to another service user. Denied any thoughts/plans."[401] There was no documented evidence that Ian was asked which tenant he had been referring to.

- 28 December 2015: It was documented that Ian "continues to be fairly over involved with another resident … [Ian] has recently learnt that a male resident he does not like and has assaulted has had a recent sexual relationship with his female friend … thoughts of harm [to] another resident that he had previously assaulted but said that he would not act on these thoughts. [Ian] had displayed some behaviours to staff last night that had been vaguely intimidating. He had stood next to a member of staff and made vague threats towards another resident."[402]

[399] Progress notes 3 March 2014
[400] AWP progress notes 10 December 2015
[401] AWP progress notes 12 December 2015
[402] AWP progress notes 28 December 2015

- 29 December 2015: Supported housing staff reported that Ian had been "quite paranoid and also made threats to smash another residents face (the same resident who [Ian] had assaulted previously). Staff also reported that Ian had made reference to purchasing a gun."[403] Ian reported that he was not happy that Kamil was living in the house, as he was "an illegal immigrant … [Ian] reported that several months ago Kamil had made threats to stab [Ian] … [Ian] reported that he was planning to make a log of Kamil's activities in the house in an attempt to get him evicted."[404]

22.4 2016

- 3 January 2016: It was noted by members of the visiting BCS that Ian spoke about Kamil and stated that he strongly disliked him but was avoiding contact with him.[405]

- 27 January 2016: The supported housing staff contacted the recovery navigator and informed them that in the past few days, Ian had been "over involving himself … being negative/derogatory about Kamil. The previous night he was repeatedly disrupting Kamil by buzzing Kamil's room … Kamil reported this to staff and they reported that he [was] quite upset about it."[406] Staff advised Kamil to call the police if he felt threatened again.[407]

- 5 February 2016: UCHA were asked by Milestones Trust to raise an Acceptable Behaviour Contract[408] relating to Ian's behaviours. This was served to Ian at a joint meeting with UCHA and Milestones Trust staff.

- 17 February 2016: During a visit by the consultant psychiatrist, the service manager reported that Ian had written a letter of complaint about Kamil but had not threated to harm him.

- 20 February 2016: There was an incident that Ian instigated that was considered by the support staff to be sexually inappropriate between Ian and another female tenant.

- 3 March 2016: Ian made an accusation against a male support worker. And his conversations with staff were at times sexual and accusatory in content.

- 4 March 2016: There was email correspondence between Milestones Trust and UCHA regarding concerns about Ian being "wound up" [409] by Kamil.

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[403] AWP progress notes 29 December 2015
[404] AWP progress notes 29 December 2015
[405] AWP progress notes 3 January 2016
[406] AWP progress notes 27 January 2016
[407] This advice was documented in Milestones Trust's chronology
[408] An Acceptable Behaviour Contract is the first stage of legal action for breach of tenancies and has no legal status but acts as a warning Acceptable Behaviour Contract
[409] UCH report for SAR p4

UCHA was advised that they should take no action until after the scheduled professional meeting had been convened.

- 19 March 2016: There was a professional meeting involving Ian's care coordinator to discuss concerns about Ian approaching a female tenant in a "sexualised way"[410].

- 28 March 2016: Ian made a comment to a support worker that Kamil should be evicted and that "he hated him"[411].

- 31 March 2016: Ian made several accusations against Kamil and was also acting in an "intimidating manner towards another tenant who he accused of protecting" Kamil.

- 1 April 2016: Ian was reported to have refused Kamil entry to the service and was making racist comments. Kamil reported the incident to the police, and the service manager wrote emails to Ian's care coordinator and Kamil's support services. Milestones Trust issued Ian with a final written warning.

- 4 April 2016: Milestones Trust contacted UCHA, requesting that a meeting with Ian be arranged. A safeguarding referral was made by Milestones Trust due to their concern for Kamil's safety as a result of the escalation in Ian's threatening behaviours.[412]

- 5 April 2016: A member of the supported housing staff team contacted the duty team to report that Ian was exhibiting "all of his early warning signs … bizarre and paranoid thinking … he [was] obsessed with everything to do with [Kamil] … becoming sexually inappropriate with staff and clients … major concerns [regarding Ian's] ongoing fixation with staff and the tenant. [Kamil]."[413] Kamil then attended a police station with Milestones Trust staff and reported the ongoing harassment from Ian. The police recorded the crime as a hate crime, which gave Kamil the status of an enhanced victim[414], and he was referred to several victim support services. Following this, the police made several unsuccessful attempts to contact Kamil, and they were unable

[410] AWP progress notes 14 March 2016

[411] Milestones Trust report for SAR p8

[412] At this time, all safeguarding referrals were initially screened by Bristol City Council's Triage Team. The Triage Team discussed the referral with Milestones Trust, and it was agreed that they would undertake their own internal investigation. This did not occur.

[413] AWP progress notes 5 April 2016

[414] The Victims' Code provides for an enhanced service for victims of the most serious crime, persistently targeted victims and vulnerable or intimidated victims. Once a service provider has identified that a victim is eligible for enhanced services, that service provider must ensure that this information is passed on as necessary to other service providers with responsibilities under the Victims' Code and to victims' services where appropriate. Service providers must share information about the victim with each other effectively and in accordance with their obligations under the Data Protection Act. Enhanced victims of crime

to complete their risk assessment. Two weeks later, the police liaised with Milestones Trust staff, who reported that Ian had received a final warning.

- 12 April 2016: There was a meeting with Ian, UCHA and Milestones Trust staff. Ian was advised that he was in breach of his tenancy agreement, and a further final warning was issued. This was followed up with a letter from UCHA to Ian on 13 April 2016.

- Between April and June 2016: UCHA were copied into a series of emails between Milestones Trust and Ian's care coordinator, which included incident logs involving Ian and other tenants. No requests were made to UCHA to proceed with further eviction action against Ian.

- 6 June 2016: An entry by UCHA stated: "Section 21[415] notice is pending against [Ian] but no formal request was made by Milestones Trust to service the Notice."[416]

- 9 June 2016: Kamil was notified that he was no longer eligible for support from Bristol City Council; he was initially given four weeks' notice of this decision. However, as Kamil's Short Assured Tenancy required a notice period of eight weeks, Bristol City Council agreed to extend their support to cover this period.

- 10 June 2016: Supported housing scheme staff found threatening notes written by Ian under the office door. The contents of the notes included delusional ideation, comments on his current state of mind, graphic sexual references, references to the mental illness of other tenants, and threats to kill particular tenants, including Kamil, and members of the public.

- 29 June 2016: At a liaison meeting, Milestones Trust advised UCHA that Ian had been detained under the Mental Health Act 1983. They asked UCHA to issue a Notice to Quit in order terminate Ian's tenancy. UCHA advised:

  "To service a Section 21 notice as this was more legally binding. The process would be a 2 month notice and then a court hearing to follow after 6 weeks of the expiry of the notice if [Ian] had not left the home. United Communities asked for all information from Milestones Trust in relation to this. This included incident logs and notes."[417]

[415] In England and Wales, a section 21 notice, also known as a section 21 notice of possession or a section 21 eviction, is the notice which a landlord must give to their tenant to begin the process to take possession of a property let on an assured shorthold tenancy without providing a reason for wishing to take possession. The expiry of a section 21 notice does not bring a tenancy to its end. The tenancy would only be ended by a land lord obtaining an order for possession from a court, and then having that order executed by a County Court bailiff or High Court enforcement officer. Section 21

[416] United communities report for SAR p4

[417] United communities report for SAR p4

This did not occur, and the next communications between Milestones Trust and UCHA regarding ending Ian's tenancy were on the day of his discharge from Cygnet Health Care's inpatient unit, details of which are outlined in the section 'Events leading up to the incident'.

Commentary and analysis

22.5 For the first three years of Ian's placement at Milestones Trust's supported housing scheme, it was being repeatedly documented that Ian maintained his accommodation well and was utilising the support offered by staff. There were no reported incidents involving Ian and other tenants, who were, it was reported, from diverse ethnicities.

22.6 From 2013 to 2016, it was documented that there were a number of significant incidents involving Ian and other tenants, frequently Kamil, in which Ian was the perpetrator of verbal and physical aggression as well as antisocial and sexually disinhibited behaviours. There were also documented incidents where Ian was exhibiting verbal aggression and intimidating behaviours towards members of the supported housing scheme's staff.

22.7 It was clearly evident that during periods when Ian's mental health was deteriorating, there was a significant escalation in his antisocial behaviours and, at times, in his physical and verbal aggression towards Kamil, as well as an escalating in his disinhibited sexualised behaviours, which were often directed towards female tenants. The latter was the main concern preceding Ian's last inpatient admission in June 2013.

22.8 Milestones Trust's staff were also reporting to AWP's practitioners that when Ian was mentally unwell, he would become fixated on Kamil's asylum seeker status; for example, he was attempting to intercept Kamil's post and questioning staff about Kamil's right to remain in the UK. Additionally, they suggested that some of the ongoing conflict between Ian and Kamil was due to their complex relationships with one of the female tenants.

22.9 There were also several incidents where Kamil was viewed as the instigator. For example, when he cut the TV cable and when he was carrying a Stanley knife, which he reported was for his own protection.

22.10 From 5 October 2013 sporadic concerns were being expressed by members of Milestones Trust's management team to both AWP's assessment and recovery team and its inpatient unit's practitioners regarding the suitability of Ian's placement at the service due to his ongoing antisocial behaviours directed towards both Kamil and other tenants. For example, it was documented at a CPA review (9 March 2014), the supported housing

scheme's manager reported that she felt that Ian "was inappropriately placed … and if he continued to upset the other residents she would give him notice"[418].

22.11 Between 5 October 2013 and 8 January 2014, Milestones Trust issued Ian with three written warnings stating that his behaviour towards Kamil and other tenants was placing his tenancy at risk. In January 2015 Milestones Trust made an unsuccessful application (15 January 2014) to the court for an interim injunction to prevent Ian returning to the service. They were required to provide additional evidence to support their application, however it appears that this was followed up and Ian returned to the service.

22.12 No further actions were taken to instigate eviction procedures until February 2016, when Ian was issued with an Acceptable Behaviour Contract and he then received a final written warning from UCHA (12 April 2016).

22.13 What was evident to the investigation team was that from 2014 there were several occasions when Milestones Trust could have sought to action eviction procedures, or, alternatively, could have convened a multi-agency meeting in order to agree with Ian a plan for him to move to alternative accommodation.

22.14 The investigation team were informed that there were difficulties in actioning an eviction notice for Ian for the following reasons:

- It is usual for tenants in a supported housing scheme to be issued with a Short-Assured Tenancy Agreement[419]. With such an agreement after the initial six-month period, a landlord can terminate a tenancy by issuing a Notice to Quit but must give at least two months' notice without having to cite specific reasons. This is called a Section 33 Notice. However, Ian had been issued with an Assured Tenancy. Under this tenancy a landlord has to wait until particular limited circumstances have occurred, giving them grounds to seek a possession order against the tenants (such as the tenant being in rent arrears).[420]

  Although there is no evidence that Ian was in rent arrears, there was a significant number of serious antisocial behaviours that collectively could have been presented to the court to support an application to evict.

- The investigation team have concluded that this was a significant missed opportunity on the housing provider's behalf to have proactively resolved the

[418] AWP progress notes 5 October 2014

[419] Short Assured Tenancies last a fixed length of time and at least six months. A landlord can terminate a tenancy at the end of this period by issuing a Notice to Quit but must give at least two months' notice – this is called a Section 33 Notice. Short Assured Tenancy

[420] Assured Tenancies

ongoing concerns regarding Ian's risk of harm to other vulnerable tenants. Such an action would also have removed Ian from an environment that was exacerbating his mental health issues.

23 Kamil's family

23.1 Kamil's family reported to the investigation team that, in their opinion, Ian's racist attitude and actions towards Kamil were not a manifestation of a deterioration in his mental health but rather, he was a person with racist views who was mentally ill. The SAR agreed with this opinion, stating that Ian:

"Held racist opinions, and his attitude towards Kamil was not the result of the deterioration in his mental health; in short, he was a person with racist views who was mentally ill, rather than a mentally ill person whose racism was a manifestation of their illness. These views crystallised into a personal hatred of Kamil that was based on his race and legal status."[421]

23.2 In April 2016 a member of the supported housing staff team contacted AWP's duty team to report that Ian was exhibiting "all of his early warning signs … bizarre and paranoid thinking … he [was] obsessed with everything to do with [Kamil] … becoming sexually inappropriate with staff and clients … major concerns [regarding Ian's] ongoing fixation with staff and the tenant [Kamil]."[422]

23.3 Kamil attended a police station with Milestones Trust staff to report the ongoing harassment from Ian. The police recorded the crime as a hate crime, which gave Kamil the status of an enhanced victim[423], and he was referred to several victim support services. The police made several unsuccessful attempts to contact Kamil, and therefore they were unable to complete their risk assessment. Following this incident Ian was issued with a final written warning.

23.4 The investigation team concluded that the incidents where Ian expressed racist opinions and hostility towards both Kamil and other tenants were clearly unacceptable. However, it cannot be ignored that the evidence does indicate that when Ian's behaviours/actions towards Kamil and other female tenants generally escalated during periods when his mental health was deteriorating.

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[421] SAR p17

[422] AWP progress notes 5 April 2016

[423] The Victims' Code provides for an enhanced service for victims of the most serious crime, persistently targeted victims and vulnerable or intimidated victims. Once a service provider has identified that a victim is eligible for enhanced services, that service provider must ensure that this information is passed on as necessary to other service providers with responsibilities under the Victims' Code and to victims' services where appropriate. Service providers must share information about the victim with each other effectively and in accordance with their obligations under the Data Protection Act. Enhanced victims of crime

23.5 It is recognised that individuals who are suffering mental health issues, such as psychoses, mood disorders or cognitive dysfunction, can exhibit antisocial behaviours as a consequence of their cognitive, emotional or relational problems and that they can express distress in verbal and physical hostility, disinhibited behaviour's, difficulty in self-regulating their behaviours and aggression. There is research that is suggesting that:

"Extreme racist delusions can occur as a major symptom in psychotic disorders, such as schizophrenia and bipolar disorder … as a mental health problem by recognizing it as a delusional psychotic symptom."[424]

23.6 Clearly such an explanation is not excusing such behaviours or minimise the profound effects on the victims, and in this case Kamil, who are being targeted. But it does offer some understanding of the causal factors that contributed to Ian's unacceptable behaviours.

23.7 The investigation team was informed that the majority of tenants, at the time, in the supported housing scheme and many of the inpatient staff, who had close contact with Ian, were from diverse ethnicities. There was no documented evidence that Ian was racially hostile or behaved in a racially aggressive manner towards them, even when he was unwell. So, this leads to the question, as the authors of the SAR suggest, of what caused the ongoing conflict between Ian and Kamil, and whether:

"The antipathy[425] between the two men has its origins in their respective vulnerabilities."[426]

23.8 Clearly, both individuals had a complex number of social and psychological difficulties, as well as traumatic life experiences, which may have contributed to the complex dynamic between them that sporadically erupted into episodes of verbal and physical conflict.

23.9 The question that the investigation team suggest is of equally importance and most relevant to this investigation is whether both Ian and Kamil's placements, in a supported housing scheme with minimal staff presence, were suitable for two individuals who had such complex presentations, risks and vulnerabilities. The investigation team have concluded that:

- Both Ian and Kamil required more intensive supported living provision.

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[424] Racism

[425] Antipathy: a deep-seated feeling of aversion

[426] SAR p16

- Kamil required a more culturally appropriate environment that could support his needs and risk factors with regard to being a refugee with mental health issues, learning disabilities and post-traumatic stress disorder.

23.10 The remit of this investigation is primarily focused on the care and treatment of Ian and not a forensic analysis of the motivation for the crime itself. However what Sancus Solution's investigation team have concluded that there were a significant number of opportunities where the involved agencies could and should have taken more proactive measures to manage the known risks and support needs of these two vulnerable men?

24 Alcohol and substance misuse

Although NHS England's Terms of Reference do not specifically ask that Ian's alcohol and substance misuse be addressed, the investigation team has highlighted that it was a significant risk factor to Ian's mental health and many of the incidents that involved other tenants, including Kamil. This section briefly documents some examples of incidents where alcohol and substance abuse were being documented as being a significant risk factor and provides a commentary on the various agencies' responses.

24.1 It was documented that[427] in July 2005, Ian had disclosed that from the age of 16 he began to experience paranoid thoughts, which coincided with him beginning to drink excessive amounts of alcohol.

24.2 By 1987 Ian's mental health symptoms were being exacerbated by his ongoing alcohol abuse, which was resulting in disinhibited and aggressive behaviours.

24.3 3 December 2012: A GP entry titled alcoholism review documented that Ian had disclosed that since his clozapine medication had been stopped, his alcohol consumption had significantly increased, and he was now drinking 150 units a week: 1-2 bottles of rum and 6 pints of beer a day. He reported that the alcohol helped him sleep and reduced the number of auditory hallucinations he was experiencing. The GP offered Ian information about a local substance and alcohol service, but Ian declined, reporting that he had a review at another service. The GP prescribed thiamine 100mg and vitamin B supplements.[428]

24.4 October 2013: It was being reported that Ian was exhibiting fluctuating psychotic symptoms, including paranoid auditory hallucinations, agitation,

[427] AWP care assessment 5 July 2005

[428] For the prevention and treatment of Wernicke–Korsakoff syndrome (WKS). WKS is a neurological disorder caused by a lack of vitamin B-1, or thiamine. The syndrome is actually two separate conditions that can occur at the same time. Alcoholism, or chronic alcohol misuse, is the most common cause of WKS. WKS

aggression and sexual disinhibition. It was documented that the sexual disinhibition was precipitated by Ian's increased alcohol consumption.

24.5 6 January 2014: The GP referred Ian to a drug and alcohol service. The referral letter commented that Ian's

"alcoholism [had] resurfaced during an episode of worsening psychosis … also [Ian] had increased his gambling and had become sexually disinhibited, spending a lot of time exhibiting arrogant and rude behaviour"[429].

The investigation team noted that this was the only time that it was highlighted that Ian may have had a gambling issue related to his alcohol misuse.

24.6 16 January 2014: Ian was offered an assessment appointment at a drug and alcohol service. There was no indication that he attended the appointment on 29 January 2014.

24.7 9 March 2014: At a CPA review, Ian agreed to be referred to a local Recovery Orientated Alcohol and Drug Service (ROADS)[430]. There was no evidence that this referral was made.

24.8 30 March 2015: Ian's recovery navigator documented that Ian's ongoing risks of violence and aggression to others were usually in the context of paranoid thinking and alcohol consumption. The risk summary documented that Ian was "aware that alcohol [could] be a trigger"[431].

24.9 May 2015: Ian was reporting to his recovery navigator that his alcohol intake had increased in the last three months, and although he was only drinking at weekends, he was consuming eight cans of strong lager and half a bottle of vodka. It was documented in his care assessment overview that Ian felt that his drinking was "problematic … he does not become aggressive but [was] worried that this pattern might lead to alcoholism"[432]. It was suggested to Ian that he began a reduction programme.

24.10 7 July 2015: Ian was reviewed by his consultant psychiatrist. Ian's alcohol consumption was discussed. It was documented in a subsequent letter to Ian from the consultant psychiatrists, which was copied to his GP, that although it was evident that Ian:

"recognised the physical health problems that drinking too much on a Friday and Saturday night have, your enjoyment of being slightly intoxicated is such

[429] Letter from GP to a drug and alcohol service 6 January 2014
[430] ROADS
[431] Risk Summary–point in time 16 March 2015
[432] Core assessment entry 27 May 2015

that you look forward to it … and would be very unlikely to change this pattern which you have done for many years. You feel it doesn't have detrimental effects on your mental health and [you have] no strong incentive to change this."[433]

24.11 30 November 2015: Ian's recovery navigator documented that she had spoken to the supported housing manager, who reported that the team suspected that Ian's alcohol consumption was higher than he was disclosing and that the team had observed an increase in his paranoid thinking.

24.12 24 December 2015: Ian disclosed to a member of BCS that his alcohol consumption had increased and that he had been sick. It was noted that the BCS practitioner had advised Ian about the contraindications of drinking with his medication.

24.13 4-5 June 2016: Ian began to disclose that he was smoking very strong cannabis (skunk) and that his alcohol consumption was increasing.

24.14 8 June 2016: Ian was discussed at the assessment and recovery service's cluster meeting. It was suggested that Ian:

"Appears to have capacity … he attributes the behaviour to being psychotic which in turn may well be linked to using skunk"[434].

- During a subsequent telephone call with the consultant psychiatrist, Ian disclosed that he had recently smoked skunk. It was assessed that Ian had:

  "Full capacity to understand [the] implications of drug and alcohol misuse on his behaviour and that some of his behaviour was entirely inappropriate."[435]

24.15 The consultant psychiatrist advised staff at Milestones Trust's supported housing scheme that if there were any further incidents involving Ian and other tenants when he was intoxicated, then they should call the police, as Ian had capacity to understand the consequences of his alcohol and substance misuse.

24.16 The only assessments and support plans that were specifically related to Ian's alcohol and substance misuse were undertake n 2013, when four Problematic Substance and Alcohol Forms were completed:

- 15 October – this was completed by his care coordinator. It documented that Ian disclosed that his alcohol use had increased "in an attempt to induce

[433] Letter to Ian 7 July 2015 cc'd to Ian's GP

[434] AWP progress notes 8 June 2016

[435] AWP progress notes 8 June 2016

sleep in the context of experiencing insomnia following an abrupt discontinuation of clozapine"[436]. He also reported that during one session of drinking, he had fallen and thought that he may have had a seizure.

- The care coordinator noted in the review on 20 November 2013 that Ian was "telling mental health staff what they wanted to hear-implying that he may not be 100% honest about his alcohol use"[437].

- This form was updated on two occasions (16 and 18 December 2013), when Ian was in AWP's inpatient unit. It was documented that he disclosed to staff "[that] his alcohol [consumption] had increased over recent weeks due to stress with his mental health and identified that this [had] contributed to him not feeling he [could] manage his thoughts and emotions and behaving aggressively"[438].

  There was no evidence that either Milestones Trust or Ian's GP contributed to or received copies of these assessments.

24.17 At times, Ian was disclosing that he was self-medicating with both alcohol and illegal substances in order to manage his symptoms. On one occasion in 2013, Ian reported that he was also misusing his prescription (Amisulpride) in combination with alcohol in "an attempt to knock himself out"[439]. On another occasion, Ian reported that he was often non-compliant with his medication regime so that he could drink alcohol.

Commentary and analysis

24.18 In reviewing the chronology, it was very evident that Ian was reporting a significant increase in his alcohol consumption and substance misuse when his clozapine medication had to be stopped. It was also at such times that his antisocial and aggressive behaviours often increased, which resulted in incidents involving other tenants, including Kamil.

24.19 The Bradley Report (2009) clearly highlighted that the co-existence of alcohol and substance misuse was a significant indicator of future significant risk of relapse and reoffending. Yet this potential was not being consistently considered in light of Ian's historic and more recent forensic history.

24.20 The issue was known to both Ian's community mental health team and GP practice, yet there was little evidence of a coordinated response. Ian clearly had been a habitual drinker and drug user from a young age, and therefore it

[436] Problematic Substance and Alcohol Form 15 October 2013
[437] Problematic Substance and Alcohol Form updated 20 November 2013
[438] Problematic Substance and Alcohol Form 16 December 2013
[439] Problematic Substance and Alcohol Form updated 20 November 2013

is perhaps not surprising that he was resistant to tackling this issue, as he was, at times, using alcohol and illegal substances to manage his mental health.

24.21 In addition to the health risks, Ian's alcohol and substance misuse was threatening the security of his tenancy with Milestones Trust. However, neither his care plans nor his Risk Summaries were highlighting this as a key issue.

24.22 There also appears to have been no consideration given to the possibility that Ian was presenting with a dual diagnosis.

24.1 Dual diagnosis covers a broad spectrum of mental health and substance misuse problems that an individual might be concurrently experiencing. The nature of the relationship between these two conditions is complex – for example, the destabilising and detrimental effects that substances can have on a patient's mental health and/or on the medication they are being prescribed for their mental health symptoms. Although the term 'dual diagnoses has been widely adopted, there has been some criticism that it implies just two distinct diagnoses, whereas it is recognised that patients, like Ian, often have multiple diagnoses, which can also include interrelated risk factors and support needs.

24.2 In such patients, consideration should be given to the possibility that a patient may be self-medicating with alcohol or illegal substances, and therefore their underlying mental health symptoms may be obscured or exacerbated.

24.3 Research has indicated that 30-50% of people with severe mental illness have co-existing substance misuse problems and that over 70% of people in contact with substance misuse services have co-existing mental health problems.[440]

24.4 The Department of Health states that this patient group present: "Significant challenges to service providers due to the complexities of their physical, social, psychological and other issues associated with this condition … [This] makes the detection, assessment, treatment and the provision of good quality care even more challenging."[441]

[440] Weaver, T., Charles, V., Madden, P., Renton, A. (2002) Co-morbidity of Substance Misuse and Mental Illness Collaborative Study (COSMIC): A study of the prevalence and management of co-morbidity amongst adult substance misuse and mental health treatment populations. Department of Health/National Treatment Agency, London Comorbidity

[441] DH 2004a, Care Services Improvement Partnership (CSIP) (2008) Dual diagnosis is 'everyone's business' (CSIP 2008) Dual Diagnosis

24.5 The Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide[442] identified that one of the biggest challenges facing front-line mental health services in their assessment and support of patients such as Ian is:

"The complexity of [formulating a] diagnosis, care and treatment with service users who are at higher risk of relapse, readmission to hospital and suicide. One of the main difficulties is that there are a number of agencies involved in a person's care – mental health services and specialist rehabilitation services, organisations in the statutory and voluntary sector."[443]

24.6 One of the difficulties in achieving a diagnosis and successful plan for patients such as Ian who are presenting with a complex number of high-risk factors is that:

- Secondary mental health services often lack the skills for supporting patients with a dual diagnosis and have limited knowledge and awareness of local substance misuse services.

These deficits can adversely affect the treatment outcomes for patients such as Ian in both their engagement and in their recovery outcomes.

24.7 Research and the various governmental drug guidance were, at the time of Ian's presentation to services, highlighting that successful support and management of patients who are presenting with a complex combination of mental health and alcohol and substance misuse issues can only be achieved:

"Through partnerships across services particularly housing, employment and mental health services … agreed pathways of care will enable collaborative care delivery by multiple agencies … Coordinated multi-agency plans, collaboration and good communication between services are important to ensure patients do not fall between the gaps."[444]

24.8 However, the investigation team concluded that this investigation has highlighted, there was little consideration of the possibility that Ian had a significant alcohol and substance misuse problem, which required a coordinated interagency response.

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[442] Mental health policy implementation guide: Dual diagnosis good practice guide

[443] Mental health policy implementation guide: Dual diagnosis good practice guide

[444] Drug Strategy 2017

25 Physical health

The investigation team have added this key line of inquiry because it has, over a number of years been universally recognised that:

> "People living with severe mental illness (SMI) face one of the greatest health inequality gaps in England. The life expectancy for people with SMI is 15–20 years lower than the general population. This disparity in health outcomes is partly due to physical health needs being overlooked. … Individuals with SMI also have doubled the risk of obesity and diabetes, three times the risk of hypertension and metabolic syndrome, and five times the risk of dyslipidaemia (imbalance of lipids in the bloodstream) than the general population."[445]

25.1 From 2008, Ian was being treated for hypertension and high cholesterol and was being prescribed simvastatin 40mg.[446] He was also being prescribed aspirin 75mg.

25.2 From 2009, Ian was repeatedly presenting to the GP with gastrointestinal symptoms, and he was prescribed omeprazole 20mg.[447] It was documented that he was also experiencing cardiovascular symptoms. A subsequent ultrasound scan reported that Ian's gallbladder was indicating chronic calculous cholecystitis.[448]

25.3 Ian's last seasonal influenza vaccination was in 2013, and after this it was documented in his GP notes that he refused any further vaccinations. There was no indication that the potential risks of not having influenza vaccinations was discussed with Ian,

25.4 In April 2014, Ian was diagnosed with gout and was prescribed allopurinol.[449] He was given information regarding his diet and alcohol consumption.

25.5 In 2011, Ian was being monitored for impaired glucose tolerance.[450]

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[445] NHS England guidance p3

[446] Simvastatin belongs to a group of medicines called statins. It's used to lower cholesterol if you have been diagnosed with high blood cholesterol. Simvastatin

[447] Omeprazole is a proton pump inhibitor that inhibits gastric acid secretion by blocking the hydrogen-potassium adenosine triphosphatase enzyme system (the 'proton pump') of the gastric parietal cell. It reduces the amount of acid in the stomach. It is also used to prevent upper gastrointestinal bleeding in people who are at high risk. Omeprazole

[448] Chronic cholecystitis is characterised by repeated attacks of pain (biliary colic) that occur when gallstones periodically block the cystic duct. In chronic cholecystitis, the gallbladder is damaged by repeated attacks of acute inflammation, usually due to gallstones, and may become thick-walled, scarred and small. Cholecystitis

[449] Allopurinol is used to treat gout and certain types of kidney stones. Allopurinol

[450] A transition phase between normal glucose tolerance and diabetes also referred to as prediabetes. With impaired glucose tolerance, a patient is at much greater risk of developing diabetes and cardiovascular disease. Impaired glucose intolerance

25.6 From September 2011, Ian's body mass index (BMI) was documented as being 34.18 kg/M2[451], and it was noted that this had significantly increased in the past three years. Advice was given to Ian regarding his diet and exercise. The GP began to discuss with Ian his concerns about Ian's elevated cholesterol levels and he was referred to a dietitian at the lipid [452] clinic.

25.7 It was documented that due to Ian's significant familial history of ischaemic heart disease, the fact that he was overweight and suffered from hypertension, and his – including being inactive and having a poor diet[453] – his 10-year cardiovascular disease (CVD) risk was 16.4%.[454]

25.8 An ultrasound reported that Ian had fatty infiltration of the liver, which had increased since his last scan. Ian was reporting that he was drinking 24 units[455] at the weekend.

25.9 Ian's last appointment with the GP prior to the incident was on 21 April 2016, t was documented that since his last weight check on 21 December 2015, when he weighed 110kg, Ian's weight had increased to 115kg.

25.10 16 January 2015: During a meeting with his consultant psychiatrist, there was a discussion with Ian about his weight, which it was documented was over 18 stone. Advice was given to Ian about reducing his portion sizes and changing the type of food he was eating. It was also suggested to Ian that he could increase his exercise, but Ian commented that "there was little prospect of this happening"[456].

25.11 30 November 2015: The consultant psychiatrist asked Ian's GP to undertake a "full annual health check"[457], as it was noted that Ian "had not had one before"[458]. In a letter to the GP, the consultant psychiatrist asked the GP to provide an "updated summary of [Ian's] current physical health"[459].

25.12 2 December 2015: It was documented that the recovery navigator intended to liaise with Ian's GP surgery regarding the annual health check of Ian that the consultant psychiatrists had requested be undertaken. It was not documented that this was undertaken.

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[451] BMI of 25 to 29 kg/m^2 and defined as overweight.
[452] Lipid clinics patients are referred if they have raised blood fats, known as lipids
[453] A person is at increased risk of CVD if your body mass index (BMI) is 25 or above. Cardiovascular risk
[454] The ASSIGN score combines all the risk factors and gives a score between 1 and 99. The higher the score, the higher the risk of cardiovascular disease. A score of 20 or more is considered to be high and is used to identify those people in greatest need of advice and treatment to reduce their risk.
[455] NHS recommends not drinking more than 14 units of alcohol a week
[456] Letter to Ian from consultant psychiatrist 16 January 2015
[457] Letter to GP 30 November 2015
[458] Letter to GP 30 November 2015
[459] Letter to GP 30 November 2015 p2

25.13 17 June 2016: One of AWP's inpatient unit's nursing staff contacted Ian's GP to ascertain information about his physical health (17 June 2016). A physical health assessment was partially completed when Ina was admitted.

25.14 30 June 2016: The Cygnet Health Care admitting doctor completed a comprehensive physical health assessment of Ian.

Commentary and analysis

25.15 The Five Year Forward View of Mental Health (2016) reminds the reader that in "2011 the Coalition government published a mental health strategy setting six objectives, including improvement in the physical health and experience of care of people with mental health problems"[460]. It is also well documented that the use of antipsychotic medications increases the physical health risks to patients.

25.16 It is acknowledged that people with mental health problems are likely to be exposed to a combination of different risk factors and have a "higher level of metabolic syndrome and co-morbidities than the general population. The physical health conditions making up metabolic syndrome include: • obesity • high blood pressure • raised blood sugar levels • abnormal cholesterol levels"[461]. From 2008, Ian's primary care records were indicating that he was consistently presenting with many of these physical health conditions and was repeatedly refusing to engage in any proactive life style changes .

25.17 Since 2014, the National Institute for Health and Care Excellence (NICE) guidelines have been advising that people with psychosis or schizophrenia, especially those taking antipsychotics, should:

- be offered a combined healthy eating and physical activity programme developed with the mental healthcare provider
- have access to the relevant national screening and immunisation programmes, as recommended by Public Health England (PHE)
- be asked about their sexual health, oral health and substance misuse[462]
- annual physical health check should include monitoring of their weight, waist circumference, pulse and blood pressure, fasting blood glucose, haemoglobin A1c test, glycated haemoglobin test, and glycohemoglobin HbA1c[463] and blood lipid levels.

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[460] Five Year Forward p4

[461] Improving the physical health of people with mental health problems: Actions for mental health nurses p12

[462] NICE

[463] Haemoglobin A1c test: indicates the average level of blood sugar over the past 2 to 3 months. HbA1c

25.18 NICE guidelines also recommend that adults living with severe mental illness (SMI) should receive annual physical health assessments. In 2014 and 2016, the NICE guidelines were updated to direct that the responsibility of monitoring the physical health of people with psychosis or schizophrenia is the responsibility of the secondary care team for the first 12 months of a patient's presentation or until the patient is stable. After that, the responsibility is shared with the patient's primary care service.

25.19 Ian's GP was involved in the regular blood testing with regard to clozapine; however, there was no evidence that Ian was receiving regular annual health checks. Although there was some communication between the GP and the assessment and recovery team with regard to Ian's physical health, it was unclear who was maintaining the overview or monitoring to ensure that Ian was receiving regular physical health checks.

CQC inspections

25.20 CQC's inspection of AWP's crisis service in 2018 commented that: "Trust policies on completing physical health checks for patients had not yet been implemented by the intensive support teams."[464] It is unclear if CQC reviewed the assessment and recovery team, but the investigation team would suggest that AWP reviews how this team undertakes and maintains physical health monitoring of patients, such as Ian, who have a complex combination of mental health and physical health issues.

Avon and Wiltshire Partnership NHS Trust

Recommendation 12: AWP should carry out a review of how the assessment and recovery team undertakes and maintains physical health monitoring of patients who have complex mental health and physical health issues.

25.21 A CQC inspection of Cygnet Health Care's inpatient unit (April 2017) reported that in response to previous CQC concerns:

"The provider had a physical health care policy in place which set out the responsibilities of a patient's admitting doctor and nurse."

This included which physical investigations should be completed in the first few days of admission.

[464] CQC inspection report p30. CQC inspection report

The hospital has increased focus on physical health following a complaint and had recently employed two ward doctors with a GP background to support and drive this.

The hospital had developed a half day training programme to support adherence to the physical health policy."[465]

25.22 The investigation team concluded that there was no consistent interagency coordinated approach to the assessment and support of Ian and his physical health risks.

26 Predictability and preventability

"Having assessed the above, to consider if this incident was predictable, preventable or avoidable and comment on relevant issues that may warrant further investigation."[466]

26.1 Throughout the course of this investigation, the investigation team have remained mindful of one of the requirements of NHS England's ToR, which is to consider whether the incident that resulted in the death of Kamil was predictable, preventable or avoidable.

26.2 The following definitions have been used:

- Predictability: 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.
- Preventable: for a homicide to have been preventable there would have to have been the knowledge, legal means and opportunity to stop the incident from occurring.[467]
- Avoidable: as at this time there is no agreed definition with NHS England as to what is an avoidable homicide, for the purpose of this investigation Sancus Solutions will be using the following Learning Disability Mortality Review Programme's[468] definition of a potentially avoidable death:

[465] CQC inspection CQC inspection report
[466] NHS England's Terms of Reference p2
[467] Preventable
[468] The National Learning Disability Mortality Review Programme is working with other agencies, such as the Learning Disability Public Health Observatory and the Transforming Care (Winterbourne View) Improvement Programme, to reduce health inequalities faced by people with learning disabilities. Learning Disability Mortality Review Programme

"where there are aspects of care and support that, had they been identified and addressed, may have changed the outcome and on balance of probability the person may have lived for another year or more"[469].

Predictability

26.3 Ian committed two historic violent assaults on members of the hospital where he had been a patient. The last assault was in June 1991.

26.4 Up until 2013, there were no reported incidents where Ian was the antagonist. This was the year that Kamil began his tenancy with Milestones Trust.

26.5 Between 2013 and April 2016, Milestones Trust recorded six incidents involving Ian and Kamil, which included threatening or actual physical aggression and verbal threats. There were also several occasions when Ian made what were perceived as derogatory racial comments about Kamil's race and his status as an asylum seeker.

26.6 There were also incidents of antisocial behaviours towards other tenants and their visitors, as well as inappropriate sexualised behaviours towards some of the female tenants.

26.7 The majority of these incidents were directly linked to periods when Ian's antipsychotic medication clozapine had to be stopped due to adverse blood results and/or when he was non-compliant with his medication regime.

26.8 On occasions, Ian was disclosing that there had been a significant increase in his alcohol and substance misuse.

26.9 On 24 May 2016, a support worker at Milestones Trust documented that Ian had talked about murder and had said that he did not care if he spent the rest of his life in jail. It is not documented if Ian disclosed any specific plan or victim. Prior to Ian's last detention under the Mental Health Act 1983, he made written threats of violence towards specific tenants, including Kamil and also members of the public.

26.10 Clearly, there were incidents where Kamil and other tenants were the victims of verbal abuse and threats from Ian. However, there were actually very few occasions when Ian carried out his threats to harm others. Indeed, the major concern, both prior to Ian's last admission to hospital and on the day of his discharge, was not the potential risk to Kamil, but the safety of the female tenants. This concern was based on the evidence that Ian had been exhibiting inappropriate and at times very threatening sexualised behaviours within the property.

[469] Avoidabledeaths

26.11 Ian's last hospital admission was uneventful. There was no evidence that t he was experiencing difficulty in self-regulating his response to the other patients or the medical staff. For example, Ian was the victim of an unprovoked attack by another patient[470], and it was documented that Ian did not retaliate and had responded proportionately to the incident. Additionally, during this admission there were no documented incidents of racial abuse towards other patients or members of staff whom Ian came into contact with who were of diverse ethnicities.

26.12 The investigation team have concluded that, based on the evidence available, there was no indication prior to his discharge that Ian was planning an attack on Kamil. There was also no evidence to indicate that before Ian left the property on 6 July 2016, he had sought information about Kamil's whereabouts.

26.13 Therefore, the investigation team agree with the AWP's SI report's finding that, based on Ian's presentation both during his last inpatient admission and on the day of his discharge, the fatal attack on Kamil was not predictable.

26.14 However, there was clearly a significant and ongoing antipathy between Kamil and Ian that had the potential to have escalated, at some point, into a more serious situation.

Preventability

26.15 In the investigation team's consideration of the preventability of this incident, the following two questions have been asked:

- Based on the information that was known, were Ian's risk factors and support needs being adequately assessed and addressed by the involved agencies?
- Based on the information that was known at the time, was the incident that resulted in the death of Kamil preventable?

  For a homicide to have been preventable there would have to have been the knowledge, legal means and opportunity to stop the incident from occurring.[471]

26.16 The investigation team agreed with both the SAR and AWP's SI report's finding that the incident on 7 July 2016 would likely have been prevented if Ian had not returned to Milestones Trust's supported housing scheme. However, this would have required one or more of the following to have occurred:

[470] 30 June 2016

[471] Preventable

- If Milestones Trust/UCHA had completed the eviction procedure and/or taken out an injunction to prevent Ian from returning to the scheme. However, due to the type of tenancy agreement issued to Ian, such procedures would have taken a considerable amount of time, and unless an injunction was issued by court, Ian would have had the right to return to his property. Moreover, creating a situation where Ian, who was a vulnerable adult, was homeless would need to have been carefully considered by those who had a duty of care for him.

- If Kamil had moved to other accommodation. Kamil had been offered alternative accommodation, but, for understandable reasons, he had rejected the option. Kamil also had tenancy rights to remain in Milestones Trust's property.

- If the police had been informed that Ian was to be discharged from the inpatient unit and had made the decision to arrest him for the threats he had made prior to his admission. However, it is not possible to know whether the Crown Prosecution Service (CPS) would have that there was sufficient evidence to have charged Ian, or if the police had made the decision to place him in prison pending a court appearance.

- If the First-tier Tribunal had decided not to discharge Ian's Mental Health Act 1983 section. However, based on evidence presented to the panel, it was assessed that Ian did not meet the criteria for further detention. It would have not been lawful to have detained Ian further on the basis that his accommodation was no longer suitable. In response to the concerns that were expressed, the First-tier Tribunal did make the decision to defer the discharge date for eight days to allow for robust multiagency discharge planning to be agreed. However, for multiple reasons discharge planning did not occur.

  It is possible that if there had been interagency communication and robust discharge planning had occurred that might have included Ian being moved directly to alternative suitable accommodation, albeit on a temporary basis, the risk of him having access to Kamil's accommodation would have been significantly reduced, and therefore this incident would have, on that night, been prevented.

Avoidability

26.17 The investigation team have already identified the set of circumstances/actions that may have prevented this incident from occurring on 7 July 2016. Based on this analysis the investigation team concluded that it was likely that the death of Kamil on 7 July 2016 could have been avoided.

Section 4

This section will be addressing the following NHS England terms of reference (ToR):

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

- If the investigations satisfied their own terms of reference.
- If all key issues and lessons have been identified and shared.
- Whether recommendations are appropriate, comprehensive and flow from the lessons learnt.
- Review progress made against the action plans.
- Review processes in place to embed any lessons learnt and any evidence to support positive changes in practice.
- Review the CCG's oversight of the resulting action plan.

To review and comment on AWP's, Cygnet Health Care's and the CCG's enactment of the Duty of Candour.[472]

To assess and review any contact made with the victim and perpetrator families involved in this incident, measured against best practice and national standards."[473]

27 AWP's serious incident investigation

27.1 Following this incident, AWP commissioned a Root Cause Analysis[474] Level 2 Comprehensive Investigation (hereafter referred to as RCA).

27.2 The investigation panel included an Independent Chair, a Patient Safety Reviewer (AWP Chair), a Consultant Nurse for Intensive Services and a Consultant Forensic Psychiatrist.

27.3 The RCA report provided information about Ian's history and a detailed chronology and analysis of AWP's involvement with Ian both in the community and prior to him being transferred to Cygnet Health Care's inpatient unit.

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[472] Every NHS trust has a statutory responsibility in relation to Duty of Candour, the Being Open principles and the ethical duty of openness that applies to all incidents and any failure in care or treatment. Duty of Candour applies to incidents in which moderate harm, significant harm or death has occurred. The guidance followed Sir Robert Francis QC's call for a more open and transparent culture in the wake of the failures in patient care at Mid Staffordshire NHS Foundation Trust. Duty of Candour

[473] NHS England Terms of Reference p2

[474] Root Cause Analysis (RCA) is a problem-solving tool used to identify how and why patient safety becomes compromised by a specific incident. A factor is considered to be a root cause if its removal from a sequence of events would prevent a final undesirable event from occurring. So rather than look at the symptomatic results of a problem, RCA attempts to address the hidden failings of a system or process. Root Cause

27.4 The SI report identified ten objectives for the investigation. These included:

"To determine the extent to which care and treatment provided by AWP services corresponded with statutory obligations, best practice, relevant guidance and local operational policies."[475]

27.5 As part of the RCA process, a multi-agency meeting was convened (7 October 2016), which was attended by representatives from the involved AWP services, managers and the consultant psychiatrist from Cygnet Health Care's inpatient unit, the police, and the city council's Principal Social Worker and Mental Health Act Manager.

27.6 Milestones Trust were invited, but it was reported that they

"were unable to attend as they were not given sufficient notice about the meeting and at this time had not been provided with information about the purpose of the investigation and their role within it"[476].

27.7 A draft chronology was presented at the RCA multi-agency meeting, and participants identified and discussed potential problems with delivery of care and treatment and good practice. Participants were also given the opportunity to comment on the draft of this report.

27.8 The RCA report provided an extensive summary of the involvement of both the community and inpatient services.

27.9 AWP's Critical Incident Overview Group ratified the SI report on 5 December 2016.

27.10 In addition to the fact that AWP did not receive a copy of the Mental Health Tribunal Report, which stated the discharge date, until after the incident, and then only on request, the following root causes were identified by the authors of the SI report:

- "[Ian] was not formally bailed by the Police in order to be admitted to hospital therefore there was no formal paperwork or note on his file about the Police interest in him and the requirement for them to be kept informed of his movements and mental health status.
- The Service Agreement between Cygnet Health Care and AWP lacks sufficient detail about roles and responsibilities, particularly in relation to discharge planning and clinical and other information sharing.

[475] AWP's SI report p47
[476] AWP's SI report p29

- There are no AWP policies or procedures to guide staff about identifying and managing the specific risks associated with Out of Trust placements and the roles and responsibilities of the different teams within AWP who have contact with these placements.

- There is no requirement for requests for specialist consultant opinions to be put in writing nor for these opinions or the outcome of Liaison meetings to be formally recorded.

- AWP does not provide staff with guidance about the circumstances when they should call 101 or 999."[477]

27.11 The RCA report also identified a number of contributory factors (CDPs). Each CDP was assessed as being high, medium or low impact. The CDP categories were care and service delivery problems.

27.12 There were 11 recommendations. Each recommendation identified which service (s) or management level it was directed at: the trust, the local division unit[478] (LDU) or the localities.

27.13 An action plan was developed for each recommendation, which identified the date for completion, the named person who had overarching responsibility for ensuring the action was completed and the evidence that needed to be submitted to provide assurance of the completed actions.

27.14 It was documented that the final report and action plan would be distributed to participants in the investigation, including external stakeholders.

27.15 The SI report and action plan was presented at AWP's Delivery Unit

27.16 Governance meeting.

27.17 AWP's SI report also identified a number of learning points with regard to post-incident management, such as:

- "Witness statements – it should be made clear to AWP line managers that it is their responsibility to ensure staff involved in serious incidents make a written statement as soon as possible after the incident, and line managers should be custodians of these statements until the Investigation Panel has been convened.

- Involvement of External Stakeholders in investigations – a single senior AWP manager should be responsible for contacting other stakeholders in writing to

[477] AWP's SI report p5
[478] LDU: the service

explain the NHS investigation process and seek their agreement in writing to participate.

- De-briefing sessions – prior to offering any further de-brief sessions for external stakeholders AWP should seek feedback from AWP and Milestones staff on the usefulness of the session held following this incident to identify if there is any learning for the Trust about how these sessions are facilitated."[479]

Post-incident support

27.18 With regard to the support provided to the involved AWP practitioners and operational manager, the SI identified a number of post-incident actions, which included:

- The community service manager attended a meeting with the assessment and recovery team to offer support and ensure that the team were able to continue functioning effectively and that the service had adequate resources.

- Members of staff who had been directly involved with Ian were offered dedicated time to discuss the case.

- A debriefing meeting was arranged, which was attended by senior managers and support workers who knew Ian or Kamil. Cygnet Health Care and Milestones Trust were also invited to attend. However, at a subsequent meeting with Milestones Trust's managers it was reported that "the way the meeting was managed and facilitated by AWP did not prove helpful to their staff and actually had an adverse impact on them"[480].

Action plan

27.19 The investigation team were provided with AWP's most recently updated action plan.

Recommendation 1

"AWP should review the procedures for information sharing and decision making when patients are transferred in either direction with all commissioned independent health care providers. The information provided for this review suggests that these crucial elements are dependent on individual practitioners who have knowledge of the requisite systems. However, it fails to consider the possibility of individual error and the need for contingency plans when a key professional is absent from work".

[479] AWP's SI report pp5-6
[480] AWP's SI report p46

- Responsible persons: Executive Director of Operations and Community Services Manager

- Action completed: 31 May 2018.

Actions

- "Internal procedures are in place to monitor admissions and discharges. Agreement on an operational procedure to manage these issues with our private providers is being sought. The Trust has a well-established out of trust placement system; this is currently being further developed to provide greater oversight of bed management generally."[481]

- The investigation team have been provided with extensive evidence that a number of policies and the contract between AWP and Cygnet Health Care have been revised since this incident:

The investigation team were also advised and saw evidence of:

- Significant restructuring in AWP's bed management processes for the monitoring of both internal and out-of-area placements. For example: arrangements have been made for the bed management team to attend ward rounds and MDT meetings for out-of-area placements in order to agree and monitor discharge planning.

- The bed management team now includes senior clinicians and there are daily meetings to review bed management issues and decisions.

- AWP's Bed Management Standard Operating Procedure (SOP) has been revised.

- AWP and Cygnet Health Care's contract has been recently revised. The investigation team noted that the new contract provides greater clarity as to discharge planning etc.

- Bristol Community service changes have resulted in the development of Facilitated Discharge workers, who are now embedded within the Crisis teams and link in with wards, including private providers.

Recommendation 2

"Discharge planning is a joint responsibility between the hospital and community mental health team. A protocol should be put in place, setting clear standards for discharge planning meetings and arrangements under the Care Programme Approach in the event of planned discharges, discharges by

[481] AWP's action plan May 2019 pp1-2

appeals, and unplanned discharges. This should include clear guidance on the requirements (AWP)."[482]

Responsible person: Bristol Community Services Manager

Action completed: 31 July 2018.

Actions

- Staff undertake CPA and risk training as per AWP policy.

- Bristol Community Service changes have resulted in the development of Facilitated Discharge workers, who are now embedded within the Crisis teams and link in with wards, including private providers.

Recommendation 3

"Arrangements should be made to ensure that Care Coordinators/case managers receive information about a service user's progress when they are in hospital and are aware of impending discharge and other developments. (AWP)."[483]

- Responsible person: Community Services Manager

Action

This issue was discussed at the Locality and Community Governance meeting (January 2017) and a local procedure was introduced for all local community teams.

This was completed on 29 February 2017.

The investigation team were advised by several practitioners and managers that they were aware of this protocol.

Recommendation 4

"The AWP bed availability policy should be revised to avoid mentally ill people in crisis remaining in the community where they are a risk to themselves and others."[484]

Reasonable person: Executive Director of Operations

[482] AWP's action plan May 2019 pp1-2
[483] AWP's action plan May 2018 p1
[484] AWP's action plan p2

Action completed: 31 July 2018.

Action

"Bed Management Standard Operating Procedure (SOP) has been revised."[485]

Responsible person: Executive Director of Operations

Action completed: 28 March 2018.

Recommendation 5

"AWP should provide guidance for all staff to assist them in deciding when to use the Police 101 (non-emergency service) and when a 999 call is appropriate. (AWP Crisis Service)."[486]

Person responsible: Community Services Manager
Action completed: 31 July 2018.

Action

- A Police Escalation Booklet had been produced and circulated to the Bristol Community teams.

Commentary and analysis

27.20 The investigation team concluded that AWP's investigation process and SI report was, in the main, comprehensive and well written. It not only provided information about AWP's involvement but also critically reviewed and highlighted where there were deficits and concerns.

27.21 With regard to whether AWP's SI report satisfied its own terms of reference, ensured that all key issues and lessons were identified and shared, and that recommendations were appropriate, comprehensive and flowed from the lessons learnt, the investigation team concluded that in the main AWP's SI report met all these criteria. However, there were several omissions within AWP's SI report that Sancus Solutions would like to highlight:

- Despite it being identified that there were deficits in the risk assessments and care planning undertaken by the assessment and recovery team, the SI authors did not investigate why this had occurred – for example, why these deficits had not been identified within either the care coordinators' or the

[485] AWP's revised action plan p3
[486] AWP's revised action plan p3

recovery navigators' supervision – nor did it consider the possibility that an audit needs to occur within this service to ascertain if this is a systemic issue that needs to be addressed.

- The SI report did not make any specific recommendation with regard to what remedial actions were required within the assessment and recovery team in order to ensure that the highlighted deficits in risk assessment and care planning were addressed.

- The SI authors did not identify or critically review the role of the recovery navigator.

- It was also not evident if Ian's GP was invited to contribute to AWP's SI investigation.

27.22 The investigation team were satisfied that AWP's action plan addressed the recommendations from their SI report. However, no evidence has been made available during the course of this investigation to indicate that AWP have in place an ongoing quality assurance process which is evaluating the impact of all changes that are being introduced as a result of their SIreports.

27.23 The investigation team would suggest that such a process is essential, as it is needed to ensure that the changes that have been made are having a positive and direct impact on the experiences of both patients and AWP's practitioners.

28 Duty of candour

AWP

28.1 AWP's SI report identified the following actions that were taken to inform both Ian's and Kamil's family members and to invite them to contribute to the investigation. It also documented the reason why Ian was not contacted.

Kamil's family

- Initially a letter was sent to Kamil's cousin, who was at the time the only known relative. Subsequently, AWP and other services became aware of other relatives of Kamil, and contact was then made – for example, there was a scheduled meeting in November 2016 where the purpose of AWP's RCA investigation was to be explained and Kamil's family were to be invited to contribute any information or key lines of inquiry.

- It is the investigation team's understanding that Kamil's family were initially provided with a redacted copy of AWP's SI report. In May 2019 they were provided with an un-redacted copy.

Ian's family

- A letter was sent to Ian's brother (3 October 2016), which contained information about AWP's SI investigation and invited him to contribute to the process. As there was no response, a panel member then made telephone contact. It was documented that Ian's brother provided "some valuable contextual information for the purpose of the review"[487].

Ian

- AWP's SI documented that a letter to Ian was initially drafted, but as there were concerns about it possibly compromising the ongoing criminal investigation, AWP liaised with the police's senior investigating officer. AWP were advised to refrain from doing so until a "formal response"[488] had been issued. It was not clear to the investigation team who was required to issue a formal response. The approved SI report noted that "a formal response had not been received. Therefore, correspondence with [Ian] regarding this investigation has not yet been pursued."[489]

- It is not evident if AWP has made contact with Ian since the criminal case was concluded to invite him to contribute to the investigation or to provide him with feedback from the SI report.

Commentary and analysis

28.2 Based on the information available, the investigation team have concluded the following:

- With regard to Ian's family, the investigation team concluded that AWP met its duty of candour with regard to notifying Ian's brother.

- It was reported to the investigation team that Ian's brother also informed the SI author that the extended family did not want to be involved in the SI process.

- It is also reported that on two occasions the SI author provided Ian's brother with information about the support that the Patient Advice and Liaison Service (PALS)[490] could offer him.

- It is not evident if AWP has offered Ian's brother or members or the extended family feedback from the completed AWP SI report. If this has not occurred, then the investigation team would suggest that remedial action is taken by

[487] AWP's SI report p33
[488] AWP's SI report p33
[489] AWP's SI report p33
[490] The Patient Advice and Liaison Service, or PALS, is an English National Health Service body created to provide advice and support to NHS patients and their relatives and carers PALS

AWP to offer to provide feedback and a copy of the final SI report to Ian's family.

- With regard to Kamil's family the investigation team concluded that AWP did meet its duty of candour, although it is of concern that it has taken so long for them to be provided with a copy of the report without redactions.

28.3 The investigation team noted that one of the SI learning points was:

"Roles and responsibilities for the Duty of Candour process should be clear so contact with patients and their families can take place in a timely and co-ordinated way and to enable the Trust to meet its statutory and contractual obligations."[491]

The report does not provide details of what the issues were, but the investigation team would like to suggest the following recommendation that would ensure that there is consistency of support and information-sharing with families post-incident and throughout the course of an SI investigation.

29 Cygnet Health Care's serious incident investigation

29.1 The authors of Cygnet Health Care's SI report were the Quality Business Improvement Lead and the Group Mental Health Act Lead.

29.2 The report provided details of Ian's forensic history and a brief summary of the events that led up to his admission to AWP's inpatient unit.

29.3 There was a detailed comprehensive chronology of Ian's admission (20 June 2016) to Cygnet Health Care's PICU, his transfer to the acute ward (28 June 2016), the Mental Health Tribunal and his subsequent discharge from the unit (6 July 2016).

29.4 The SI report concluded:

"We do not believe that it is possible to establish a root cause during this investigation. There are no factors above which would have indicated a failing by Cygnet Hospital [inpatient unit] which would have directly led to the incident which allegedly occurred on 7 July. Following the direction by the First Tier Tribunal there were no changes in [Ian's] behaviour which would have enabled the team at Cygnet Hospital [inpatient unit] to have been able to pre-empt this alleged incident or to have had reason to have detained [Ian] further. [Ian] refused to stay as an informal patient at Cygnet Hospital

[491] AWP's SI report p36

[inpatient unit] and therefore he was free to leave from 4pm on the 6th July 2016."[492]

Action plan

The following section will document the original recommendations and also the latest information supplied by Cygnet Health Care regarding the progress that has been made on their implementation.

29.5 Alongside a number of good practices that were identified, four care and service contributory factors were highlighted, and associated recommendations were made:

Contributory factor 1
'Little information was received about [Ian's] previous history or his behaviour since admission to [AWP's inpatient unit]. During the investigation it has been established that a safeguarding investigation that was ongoing had not been made available to the team at [Cygnet Health Care's inpatient unit] which may have been relevant at the tribunal.

- The tribunal was also held 5 days after [Ian] had made an application which did not allow much time for information to be sought or gathered by the team at [Cygnet Health Care's inpatient unit]. It is very hard for the staff to ask for information they do not know is in existence which means they are very reliant on the referrers passing information on."

Recommendation
"In acute environments this is an ongoing issue but I would recommend that the Cygnet inpatient team arrange a meeting with AWP to discuss how going forward all information can be made available and post admission where the team should be targeting their requests."

Actions
- To review admission criteria and monitor information-gathering for new admissions to build care plans and risk profiles.

- Cygnet Health Care's patient discharge or transfer form relaunched and disseminated within its discharge policy.

- Launch and formation of the Cygnet Central referral line for referrals to Acute and PICU in order to enable better standardisation of pre-admission information.

[492] Cygnet Health Care SI report p22

- Clinical Risk Assessment and Management Policy updated. Inclusion of risk assessment tools (START) and daily risk assessments implemented across all units/services with links to discharge planning. Specific mention of sources to be documented in order to gather information on present and historical risk indicators.

Contributory factor 2

- "There had been an assumption that the home team would have created a plan for discharge since [Ian's] tribunal decision had been given.

- The Cygnet Informal Patient discharge or transfer form to be completed. This form was not used in line with policy."[493]

- Audit and monitor information-gathering for new admissions to build care plans and risk profiles.

- Standardisation of information required for admission.

Actions

- Quality Assurance Managers (QAMs) to monitor use of the discharge form at local level via QAM assurance reports.

- To have direct communication with the discharge destination to share discharge plans.

- Review of Discharge Policy -to include mention of communications and engagement with the discharge destination.

- For staff to be made aware of the patient discharge or transfer form and checklist and for it to be used going forward.

- Review of patient's triplicate[494] discharge or transfer form by the Operational Improvement Director.

Contributory factor 3

- Nursing report for the tribunal did not meet the requirements set by the First Tier Tribunal guidance.

Recommendation

"For a corporate review to be done of the guidance provided to nursing staff to ensure it is in line with the practice direction provided by the First Tier Tribunal."[495]

[493] Cygnet Health Care SI report pp21-22

[494] Triplicate typically refers to a document created three times simultaneously

[495] Cygnet Health Care SI action plan pp21-22

Actions

- Corporate review of the guidance provided to nursing staff to ensure it is in line with the practice direction provided by the First Tier Tribunal.

- Mental Health Act Lead to review guidance.

- To outsource MHA training.

- To incorporate report-writing into the MHA training – "this will improve the quality and assurance of the training we are providing and enable more targeted training for nurses writing tribunal reports"[496].

Contributory factor 4

"Cygnet Health Care have a form that should be used when an informal patient is discharged." [497]

Recommendation

- "For staff to be made aware of the form and for it to be used going forward. To review RCA investigation process as we failed to identify risk history in the RCA process and to review partnership investigations."[498]

Actions

- "To have direct communication with the discharge destination to share discharge plans.

- Discharge policy - Policy for the Discharge of Service Users to include mention of communications and engagement with the discharge destination."[499]

The latest action plan documented that all actions have been completed.

Commentary and analysis

29.6 Sancus Solutions were provided with the relevant updated policies and procedures.

29.7 With regard to how Cygnet Health Care incorporates and monitors SI recommendations the investigation team were informed that:

"Approved recommendations and lessons learned are to be incorporated into the unit Overarching Local Action Plan (OLAP). The Corporate Risk Manager

[496] Cygnet Health Care SI action plan pp21-22
[497] Cygnet Health Care SI action plan pp21-22
[498] Cygnet Health Care SI action plan pp21-22
[499] Cygnet Health Care SI action plan pp21-22

will ensure that any corporate learning is disseminated across Cygnet Health Care."[500]

29.8 The investigation team were satisfied that Cygnet Health Care has addressed the recommendations from their SI report. However, as has been identified with AWP, no evidence was made available that an ongoing quality assurance process is in place which is evaluating the impact of all changes that are being introduced as a result of Cygnet Health Care's SI reports.

29.9 The investigation team suggest that such a process is essential, as it is needed to ensure that the changes that have been made are having a positive and direct impact on the experiences of Cygnet Health Care's practitioners and patients.

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) and Cygnet Health Care

Recommendation 13: AWP and Cygnet Health Care should consider recruiting a family liaison officer, who would be the single point of contact and provide support for families throughout the serious incident investigation process.

Cygnet Health Care and Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)

Recommendation 14: At Sancus Solutions' six-month quality assurance review, AWP and Cygnet Health Care must demonstrate that they have a quality assurance process in place that monitors and evaluates the impact of changes that have been made as a result of recommendations from their serious incident investigations.

Post-incident support

The SI documented in the section 'Arrangements for Shared Learning':

"We established that some staff were unable to participate in the debrief which did occur following [Ian's] discharge and it would be useful for a further debrief to take place to ensure all staff who cared for [Ian] feel supported and have an opportunity to obtain feedback from this investigation."[501]

[500] Cygnet Health Care SI report p22
[501] Cygnet Health Care SI report p22

29.10 It was unclear to the investigation team if the additional debriefing session had taken place. It also appeared from the interviews that were undertaken by the investigation team that not all of the involved practitioners had received feedback from Cygnet Health Care's SI report.

Commentary and analysis

29.11 Cygnet Health Care's SI report provided a comprehensive chronology of and commentary on Ian's admission.

29.12 Although the SI report identified that there were significant deficits in information about Ian which resulted in:

- Lack of detail in the nursing and consultant psychiatrists' reports for the Mental Health Tribunal

- Failure to develop a discharge plan.

  The SI report appears to imply that the deficits in information-sharing were mainly the responsibility of AWP and Milestones Trust staff and not their inpatient unit. This report has repeatedly highlighted that all the involved practitioners, including Cygnet Health Care's inpatient unit, had equal responsibility and opportunities to obtain information to inform assessments and Mental Health Tribunal reports.

- The SI authors do make reference to the need to improve information sharing with regard to AWP but does not highlight other agencies that may be involved: for example, a patient's support or housing service.

- The investigation team have concluded that there was a considerable amount of information included in AWP's referral to Cygnet Health Care. Additionally:

- On 22 June 2016, AWP's inpatient unit telephoned Cygnet Health Care's PICU ward to obtain an update on Ian. This was a missed opportunity where further information about Ian could have been obtained.

- There was also at least one occasion when Ian's brother – whom Ian had given his permission for information to be shared with – visited him. This was another missed opportunity where additional information about Ian could have been obtained.

Cygnet Health Care's Duty of Candour

29.13 Cygnet Health Care's SI report stated:

"This alleged incident occurred after the service user had been discharged and therefore the responsibility of contacting the service user's family will have fallen to other organisations. Due to this being a current police investigation we have been informed that it is not appropriate for us to make contact with the service user's family."[502]

The investigation team did not agree with the decision that it was only AWP's responsibility to contact Ian's family as the incident occurred less than 12 hours after Ian was discharged from Cygnet Health Care's inpatient unit; therefore, they were the most recent provider of care and treatment.

29.14 Clearly contacting a family against the direction of the police is not advisable however AWP did have contact with Ian's brother without compromising the on-going police investigation. In future cases where AWP and Cygnet Health Care are completing SIs about a patient consideration should be given to jointly contacting and meeting with family members. This would also minimise the intrusion for families at such a complex and distressing time.

29.15 Additionally, after the trial had finished Cygnet Health Care did have an opportunity to approach both Kamil's and Ian's family to offer to provide receive feedback from their SI report.

29.16 NHS England's Serious Incident Framework repeatedly reiterates the importance of involving families in SI investigations, not only to provide them with post-incident support, but also to provide them with:

"The opportunity to express any concerns and questions. Often the family offer invaluable insight into service and care delivery and can frequently ask the key questions."[503]

29.17 Inviting Ian's family to be involved would have provided a valuable source of information that would have informed Cygnet Health Care's investigation and would have provided another source of support for Ian's family.

29.18 NHS England's Serious Incident Framework also directs that when a health care provider is undertaking an SI investigation where a homicide has been committed, they must:

"Ensure families (to include friends, next-of-kin and extended families) of both the deceased and the perpetrator are fully involved. Families should be at the centre of the process and have appropriate input into investigations."[504]

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[502] Cygnet Health Care SI report p4

[503] NHS Serious Incident Framework p38. Serious Incident Framework

[504] NHS Serious Incident Framework p49. Serious Incident Framework

There is no evidence that Cygnet Health Care considered contacting, either directly or via the police's family liaison officer, Kamil's family to notify them that they were undertaking an SI investigation, or to invite them to contribute to their terms of reference.

29.19 Clearly, it would have been important not to overburden or intrude on either Kamil's or Ian's families at such a complex time or compromise any ongoing criminal investigation. NHS England's Serious Incident Framework advises that:

"Depending on the nature of the incident, it may be necessary for several organisations to make contact with those affected. This should be clearly explained to the patients/victims and families as required. A co-ordinated approach should be agreed by the partner agencies in discussion with those affected."[505]

This is another occasion where greater interagency liaison between AWP and Cygnet Health Care was required.

29.20 The investigation team would suggest that Cygnet Health Care's lack of involvement of agencies and the families of both Ian and Kamil in their SI investigation was a significant error, as both would have greatly enhanced the contents and quality of the investigation.

29.21 There was no evidence to indicate if Ian has been provided with feedback from Cygnet Health Care's SI report.

29.22 The lack of engagements with families and Ian was non-compliant with Cygnet Health Care's Duty of Candour and their own Patient Safety policy, which clearly identifies the requirement to notify and involve patients and their families in post-incident investigations and to give them access to SI reports.

29.23 The investigation team noted that this policy did not appear to clarify how Cygnet Health Care is expected to be involved in other sectors' SI investigations. The investigation team would suggest that this policy needs to incorporate such guidelines.

30 Clinical Commissioning Group

"To review and test the Trust and Clinical Commissioning Group's governance, assurance and oversight of serious incidents with particular reference to this incident."[506]

[505] NHS Serious Incident Framework p49. Serious Incident Framework

[506] NHS England Terms of Reference p2

30.1 The investigation team were informed that the CCG, who has responsibility for monitoring AWP have the following assurance structures in place:

- Monthly Quality Subgroup meetings where serious incidents themes and trends are discussed.
- Weekly SI panel meetings
- Integrated performance meetings where incidents are reviewed which have occurred in their commissioned services.
- A representative from the CCG also sits on the safeguarding audit subgroup (SAR). One of the functions of this group is to monitor SARs and associated action plans. One of the functions of this group is to monitor SARs and associated action plans.

30.2 The investigation team were informed that Cygnet Health Care presented their SI action plan to SAR audit subgroup on 4 February 2019.

30.3 The investigation team were also informed that despite several requests being made at the point of this report being written AWP has not submitted their latest action plan to either the CCG or the safeguarding audit subgroup.

30.4 It was reported to the investigation team that one of the major challenges for the CCG has been the fact that there has been a significant and repeated personnel change within AWP's safeguarding adult team. This has resulted in a lack of consistent presence at meetings and responses to their repeated requests to obtain the SAR and SI action plan. However, it was reported that it is envisaged that with the recent recruitments within AWP that this will be resolved in the near future.

30.5 The investigation team were unable to ascertain why AWP have not been in the position to forward their action plan to their CCG and the safeguarding audit review subgroup (SAR). Especially as an action plan was, on request, forwarded to the investigation team.

30.6 Clearly AWP and the CCG need, as soon as possible, to both identify and rectify the difficulties and ensure that propionate remedial and prompt actions are taken to not only to comply with their commissioning requirements but also to provide evidence to both Kamil and Ian families that all actions have now been completed.

CCG's duty of Candour

30.7 The CCG reported that they have had no direct contact with either Kamil or Ian's families.

30.8 Sancus Solution's investigation team were informed that the duty of candour responsibility to the relevant person/family rests with the provider when the CCG is not directly involved with the incident. The CCG requires all of the services they commission to have a Duty of Candour policy in line with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20[507]. Duty of Candour is monitored by the CCG though the SI process.

30.9 The CCG also requires documented evidence, within both an agency's 72-hour report, that is submitted after a serious incident and their Root Causes Analysis report, of their duty of candour actions, which involved the support and involvement of families post incident.

31 Concluding comments

31.1 This is a very tragic event that involved the loss of the life of Kamil, who was a vulnerable adult who had experienced many significant traumas in his life. His death will continue to deeply affect the lives of everyone who was involved, but most especially his family.

31.2 Although the investigation has highlighted some concerning issues with regard to the care and treatment of Ian, it is not being suggested that any one individual practitioner was directly responsible for this tragic event. The aim of these independent investigations is to identify where there have been particular practice concerns and to highlight where practice, policies and governance structures are not robust enough. Ultimately, this report aims to identify where there are lessons to be learnt in order to improve future delivery of services in all the involved agencies.

31.3 Sancus Solutions hope that the findings and recommendations of this investigation will contribute to the learning and development of all the practitioners involved and support them to improve their practices and service delivery to vulnerable patients. It is also the hope of the investigation team that the findings and recommendations within this report provide the families of Kamil and Ian with at least some resolution to their questions and concerns.

[507] Health and Social Care Act 2008

32 Recommendations

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)
Recommendation 1: AWP should review the recovery navigators' induction and ongoing risk assessment training programme to ensure that they have a skill base that is commensurate with the expectations of the role.

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)
Recommendation 2: AWP should introduce a quality assurance process that provides ongoing monitoring of risk assessments and risk management plans that are being completed by the recovery navigators within their assessment and recovery teams.

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)
Recommendation 3: AWP should undertake an urgent review of their CPA and Risk Policies to ensure that they provide clarity regarding recovery navigators' responsibilities in relation to care coordination and the assessment of risks.

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)
Recommendation 4: When a patient is receiving support from both a care coordinator and a recovery navigator, regular joint supervision should be undertaken to ensure that an appropriate level of risk assessment and care planning is being provided and to identify when the involvement of a senior clinical practitioner is required.

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)
Recommendation 5: AWP should develop a more comprehensive Risk Summary point in time pro forma.

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)
Recommendation 6: AWP should establish an information sharing protocol between all agencies involved in the provision of services within Bristol Mental Health

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) and Cygnet Health Care
Recommendation 7: AWP should consider the feasibility of allowing Cygnet Health Care's inpatient unit to have access to a patient's AWP records.

Milestones Trust
Recommendation 8: Milestones Trust should adopt a comprehensive risk assessment tool that is used by either statutory services or other third sector agencies.

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)
Recommendation 9: Members of the assessment and recovery team should be provided with a continuous professional development session on the role and function of the police's Potentially Dangerous Person (PDP) scheme.

Cygnet Health Care, Avon and Wiltshire Mental Health Partnership NHS Trust (AWP), and Milestones Trust
Recommendation10: Cygnet Health Cares, AWP's inpatient unit, and Milestones

Trust should review their practice with reference to the Triangle of Care's six key elements of carer engagement.

Cygnet Health Care

Recommendation 11: Cygnet Health Care should consider the viability of introducing electronic continuous records in their inpatient units.

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)

Recommendation 12: AWP should carry out a review of how the assessment and recovery team undertakes and maintains physical health monitoring of patients who have complex mental health and physical health issues.

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) and Cygnet Health Care

Recommendation 13: AWP and Cygnet Health Care should consider recruiting a family liaison officer, who would be the single point of contact and provide support for families throughout the serious incident investigation process.

Cygnet Health Care and Avon and Wiltshire Mental Health Partnership NHS Trust (AWP)

Recommendation 14: At Sancus Solutions' six-month quality assurance review, AWP and Cygnet Health Care must demonstrate that they have a quality assurance process in place that monitors and evaluates the impact of changes that have been made as a result of recommendations from their serious incident investigations.

Appendix A Terms of Reference

Independent investigation into the care and treatment of [Ian] by Avon and Wiltshire Partnership NHS Foundation Trust and Cygnet Health Care

Purpose of the investigation

To identify whether there were any gaps, deficiencies or omissions in the care and treatment that [Ian] 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

Review the quality of assessment and treatment plans that were provided by all NHS provider organisations and including, non-NHS organisations identified in the level 2 investigations from August 2015.

Review the risk assessment and risk management plans in place at the time of the incident, with particular reference to risks posed to the victim, and other vulnerable adults and whether they were appropriately shared and understood by all agencies involved in the care and treatment of [Ian]

Review and assess the quality of all clinical risk assessment to determine if [Ian] posed specific risks to the victim based on their ethnicity, gender, race, religion or culture. If risks of this nature were identified, were they formulated as potential Hate Crimes and were appropriate steps to mitigate/address those risks taken

Review the quality of discharge planning between community services, inpatient services and the Housing Provider.

Review the effectiveness of communication, information sharing and decision making between agencies and services, including the Housing Provider, local Police and Adult Safeguarding Services.

Review the rationale for the allocation of a Band 4 worker from the AWP Recovery Service, to an individual with an extensive and complex psychiatric/forensic history and comment as to whether that was appropriate.

Review the appropriateness of the decision-making processes and outcomes with specific reference to the transfer between inpatient services.

Comment on the quality of involvement of the perpetrator's family in the assessment and treatment of [Ian].

Review the documentation and record keeping of key information by the Avon and Wiltshire Partnership NHS Foundation Trust, Cygnet Health Care against its own policies, best practice and national standards.

Comment on the processes of mental health act tribunals when Service users are transferred between services and providers mid-application.
Review the decision making of the Mental Health Review Tribunal, commenting on the quality of information provided to that group.
Review the Trust's and Cygnet Health Care's internal investigation report assess the adequacy of its findings, recommendations and implementation of the action plan and identify:

i. If the investigations satisfied their own terms of reference.
ii. If all key issues and lessons have been identified and shared.
iii. Whether recommendations are appropriate, comprehensive and flow from the lessons learnt
iv. Review progress made against the action plans
v. Review processes in place to embed any lessons learnt and any evidence to support positive changes in practice
vi. Review the CCGs oversight of the resulting action plan.

Having assessed the above, to consider if this incident was predictable, preventable or avoidable and comment on relevant issues that may warrant further investigation. To review and comment on AWPs, Cygnet Health Care and the CCGs enactment of the Duty of Candour.
To assess and review any contact made with the victim and perpetrator families involved in this incident, measured against best practice and national standards
To review and test the Trust and Clinical Commissioning Group's governance, assurance and oversight of serious incidents with particular reference to this incident
To assess and review any contact made with the families involved in this incident.
To review the Trust's family engagement policy for homicide and serious patient incidents, measured against best practice and national standards.
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:

i. 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
i. Arrange an initiation meeting between the Trust, commissioners, investigator and other agencies willing to participate in this investigation
ii. Seek full disclosure of the perpetrator's clinical records to the investigation team

Outputs

We will require monthly updates and where required, these to be shared with families

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

A chronology of the [Ian's] mental health and forensic history dating back to 2013 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

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, proofread and shared and agreed with participating organisations and families (NHS England style guide to be followed)

Meetings with the victim and perpetrator families and the perpetrator to seek their involvement in influencing the terms of reference.

At the end of the investigation, to share the report with the Trust and meet the victim and perpetrator families and the perpetrator to explain the findings of the investigation and engage the Clinical Commissioning Group with these meetings where appropriate.

A concise and easy to follow presentation for families.

A final presentation of the investigation to NHS England, Clinical Commissioning Group, provider Board and to staff involved in the incident as required

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

The investigator will deliver learning events/workshops for the Trust, staff and commissioners as appropriate.

Appendix B Bibliography

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- NHS Serious Incident Framework. Serious Incident Framework
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- Western Journal Is Extreme Racism a Mental Disorder 2002 Racism

Appendix C Investigation Team

Grania Jenkins is the lead investigator for this highly complex investigation. Grania has a background as both a practitioner and a senior manager for adult and children's and young people's mental health services. She has also worked in senior management positions in performance and quality within the health and social care sectors. Grania has extensive experience of undertaking high-profile and complex homicide investigations, under NHS England's Serious Incident Framework.

Dr Oliver White provided psychiatric advice to the panel and undertook interviews. Oliver is a forensic psychiatrist who has extensive experience of working within secure inpatient units. He has also delivered multidisciplinary training on risk assessment and risk management and has been a Clinical Services Director and a Named Doctor for Safeguarding Children. Oliver has also provided expert evidence in high-profile criminal cases, including homicide cases.

Ray Galloway was a Detective Superintendent in the police force. After his retirement, he was appointed as one of the independent investigators into the activities of Jimmy Savile. In this investigation, Ray has acted as the critical friend, providing a level of independent scrutiny to the investigation.

Tony Hester is one of the Directors of Sancus Solutions and has provided the quality control and governance oversight of this investigation process. Tony has over 30 years' Metropolitan Police experience in Specialist Crime investigation. Since 2009 Tony has coordinated and managed numerous Domestic Homicide Reviews (DHRs) for Sancus Solutions where the mental health of the perpetrator and/or victim has been a significant and contributory factor. Tony has provided the quality assurance for this investigation.

Appendix D Interviews

Interviews were carried out with the following:

AWP

Assessment and recovery service – care coordinator
Assessment and recovery service- recovery navigator
Assessment and recovery service- Team Manager
BCS service manager – at the time involved with the BCS
Lead Patient Safety Reviewer- SI author
Head of Patient Safety Acting
Director of Operations
Out of Area placement manager
Clinical and Assistant Clinical Directors
Director of Nursing – telephone interview.

Cygnet Health Care

Inpatient consultant psychiatrists x 2
Charge nurse
Clinical Team Leader.
Inpatient mental health nurse x 2
Nurse in charge
Clinical Manager
Staff nurse
Corporate Safeguarding Professional- telephone interview.

Milestones Trust

Support workers x 4
Chief Executive
Service manager
Assistant Director of Operations
Area Manager.

CCG

Head of Adult Safeguarding- telephone interview.