

Report to NHS England of the
Independent Investigation
commissioned by the former North
East Strategic Health Authority into
the care and treatment of Patient C

The Panel

The members of the panel were:

- Mr Euan Duff – Barrister (Chairman)
- Dr Ahmad Khouja – Consultant Psychiatrist, Deputy Medical Director and Clinical Director of Forensic Services, Tees, Esk & Wear Valleys NHS Foundation Trust
- Mr Harry Cronin – former Executive Director of Nursing, Tees, Esk & Wear Valleys NHS Foundation Trust

Mr Euan Duff



Dr Ahmad Khouja



Mr Harry Cronin



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Introduction

On 15 July 2007 Patient C killed Victim C by stabbing him five times with a kitchen knife. At that time both Patient C and Victim C were resident at a hostel in Blyth. There had been a short history of trouble between Patient C and Victim C and immediately before the killing there had been an argument and fist fight between them. Victim C armed himself with a sock containing a snooker ball and went to the room of Patient C inviting him to fight and the incident then occurred in which Victim C struck Patient C with his weapon and Patient C fatally stabbed Victim C.

On 30 June 2008 Patient C pleaded guilty to the manslaughter of Victim C on the basis of provocation and, on 15 September 2008, he was sentenced to a term of 4½ years imprisonment in respect of that offence.

At the time of the death Patient C was under the care of the secondary mental health services provided by Northumberland, Tyne and Wear NHS Foundation Trust (NTW) having been involved with those services since January 2001 for prolonged periods. Under the terms of Health Service Guidance (94) 27 (as amended 2005) the North East Strategic Health Authority commissioned this independent investigation into the health care and treatment of Patient C with the terms of reference set out hereinafter.

The panel met on 34 occasions between 2 August 2011 and 22 March 2013. The panel had access to all of the documentation listed in the bibliography at the end of the report; it interviewed nine witnesses who were requested to attend and did so willingly; it also received a written submission from a further witness who was not interviewed. The panel wished to interview the residential support worker at the hostel where Patient C was resident at the time of the killing but she was unavailable. The panel also wished to interview Patient C himself and indicated that to him, but he declined.

The interviews of all witnesses were contemporaneously recorded and they were provided with transcripts of the interviews and given the opportunity to amend any matter on the record that they regarded as inaccurate.

The panel was aware that it was in the uniquely advantageous position of being able to consider the care and treatment of Patient C without the pressures of the day-to-day management of numerous patients for whom clinicians and other professionals have responsibility. It has attempted to guard against the wisdom of hindsight.

The panel has considered the entire history of Patient C's involvement with mental health services from his first involvement in 2001 until the death of Victim C.

Terms of Reference

Terms of Reference for an Independent Inquiry into the Healthcare and Treatment of Patient C

To examine the circumstances surrounding the health care and treatment of the above patient, in particular:

- the quality and scope of his health care and treatment, in particular the assessment and management of risk;
- the appropriateness of his treatment, care and supervision in relation to the implementation of the multi-disciplinary Care Programme Approach and the assessment of risk in terms of harm to himself or others;
- the standard of record keeping and communication between all interested parties;
- the extent to which his care corresponded with statutory obligations and relevant guidance from the Department of Health; including links to MAPPA.
- prepare a report of the findings of that examination for, and make recommendations to, the North East Strategic Health Authority.

Narrative Chronology

Early years

Patient C was born on 26 November 1984. The panel obtained only limited knowledge of his early years. His mother was 16 years of age when he was born and his father said to be about the same age. Patient C later reported that his parents separated when he was 10 years of age and that a new partner came to live with his mother. He said that there was a good deal of violence between his mother and both his father and stepfather and also reported other anti-social and disruptive behaviour within the family. He has two sisters 4 and 7 years younger than him.

Amongst the incidents of violence and disruptive activity he said that his stepfather set fire to the family home when Patient C was 13, which resulted in the rest of the family having to move to a women's aid shelter and Patient C going to live with relatives. Patient C reported that he was often in trouble at school and was expelled at the age of 16; he was to say for using drugs. Throughout his life he appears to have moved from one address to another, mostly in the Blyth and Cramlington areas of Northumberland, but also briefly to Darlington at one point.

January 2001 to May 2001

In January 2001 Patient C had his first contact with the psychiatric services. This followed several months of marked symptoms. He was referred, on 24 January 2001, by his GP to the Young People's Unit in Newcastle, (YPU) as he was reported to have been behaving in a strange manner over the last few weeks. He was not going to school and thought that he was getting messages from the television. He reported that he had been taking cannabis the previous summer but said that he had not had any in the last six months. He was said to become aggressive if anybody asked him about his behaviour. He was taken to the YPU on 26 January 2001 by his parents and admitted informally. By 29 January 2001 he was no longer willing to stay on an informal basis but had admitted to various psychotic phenomena such as visual and auditory hallucinations, thought interference and delusional ideas. He was detained under Section 5(2) of the Mental Health Act 1983 (MHA) and subsequently Sections 2 then 3.

A full assessment recorded that he had been experiencing marked visual hallucinations, believing he was the chosen one of the devil and seeing horns on his own head when he looked in the mirror. He also saw people's faces change into vampires and believed that cars had spirits of their own. He had demanded monies from banks. He had also been violent to his mother, slapping her in the face and had smashed a plant pot in his uncle's face, which resulted in the uncle needing 20 stitches.

He was prescribed Olanzapine and, initially, intramuscular Acuphase. He was very thought disordered at first but this gradually resolved, although he remained suspicious and only had fleeting insight into his difficulties. After six weeks on Olanzapine he was commenced on depot Haloperidol, which was gradually increased to 200 mg fortnightly. He had a clear diagnosis of paranoid schizophrenia. He was discharged from Section 3 on 23 April 2001 although he remained an inpatient on a voluntary basis before being sent on extended leave from 30 April 2001 and discharged from hospital on 14 May 2001 with provision for ongoing outpatient follow up. Prior to discharge he had been referred, on 3 May 2001, to the community team in Cramlington in order to ensure that he had ongoing support from them to attempt to re-integrate him socially.

Commentary

The panel is of the view that this first period of inpatient care was appropriate and in accordance with what might have been expected given the severity and duration of the episode. There was a firm diagnosis based upon the evidence of the symptoms with which Patient C had presented and appropriate treatment was given. The discharge summary to his GP sets out an accurate account of what had occurred, although it is somewhat brief in the description of the symptoms Patient C had displayed, makes no reference to his having been referred to the community team, does not contain any advice in the event of problems recurring and has no detailed plan for his future treatment.

May 2001 to January 2003

CPN1 became involved with Patient C's care as a result of the referral to the community team from 10 May 2001, attended an out-patient appointment on 31 May 2001 and assessed Patient C over a number of weeks. There was a full risk assessment and he was registered under the Care Programme Approach (CPA) as being on enhanced care co-ordination on 2 July 2001. It was noted that he was subject to Section 117 MHA after care. He returned home to live with his mother but was experiencing a high level of anxiety and a loss of confidence. He was very dependent upon his mother for reassurance and support. He was referred to an occupational therapist who planned to increase Patient C's level of independence, develop skills, plan his time and create routines and structures for the week, increase his level of activity and increase his confidence and self-esteem through meaningful activities. He was seen on a weekly basis until 17 October 2001 and appeared to make reasonable progress. When the occupational therapist left her post at that time Patient C decided not to continue under a new therapist.

Throughout that time Patient C was seen on a regular basis at home by CPN1 and he continued to make reasonably steady progress and received his depot injections. There were some ups and downs. In early August 2001 his mother was admitted to hospital with a heart problem and Patient C was looked after by his aunt and grandmother. On August 20 2001 he reported that he had smoked some "tac" the previous weekend and had started "to see the devil". There were some concerns about his drinking. Patient C was reviewed on 29 October by Consultant 1, from the YPU, who was very concerned about the risks to his mental health posed by Patient C's use of illicit drugs and alcohol. By this stage Patient C had begun to become more hostile towards his mother and sisters, which was regarded as an early warning sign of possible relapse. He had no insight into his illness and questioned the need for the involvement of professionals. At this time ASW1 took over as Patient C's care worker from CPN1. Over the Christmas period although he continued to receive his depot medication, there were some concerns about violence towards his mother. In early January 2002 a row in which Patient C hit his mother resulted in his having to move out.

He then lived with various relatives - his grandmother, his father, his aunt and his uncle for the first half of 2002. There were some concerns in relation to his living with

his uncle who was known to use alcohol heavily. Despite these various moves Patient C seemed quite well during this period, was visited weekly and received his depot injections regularly. On 22 May 2002 he was taken to Newcastle General Hospital for an MRI scan and on 1 June for an EEG both of which were normal. On 1 July 2002 Patient C's mother reported to ASW1 that she felt that Patient C was becoming unwell, was concerned that he was having hallucinations and believed that he had been using cannabis with his uncle.

On 3 July 2002 he was seen at home and several psychotic features were noted with some auditory and visual disturbance and ideas of reference. He confirmed that he had used cannabis heavily for a week with his uncle. He was willing to see Consultant 1 and was not opposed to going into hospital. The next day he was taken by ASW1 to the YPU and was admitted on an informal basis. He reported that he had had a lot of stressful events in his life over the past months, had not been taking his Olanzapine in the past few weeks and had been smoking a lot of cannabis. He had been hearing voices and the previous day believed that he could see the devil in the mirror. His mood was flat but he showed some insight into his mental health problems, and was willing to stay on the YPU in order to get himself on an even level in relation to his illness. He remained as an in-patient until 10 July 2002. During his stay a clear plan was embarked upon to encourage Patient C to engage in activities and to attempt to give him a greater insight into his mental health difficulties. There was good liaison between the hospital staff and ASW1 and consideration was given to where Patient C would live on discharge. His mother had very significant problems at this time and it was considered that it would be better for Patient C to live with his aunt. Reasonably good progress was made but by 9 July 2002 he was still displaying some symptoms and had had nightmares about the staff wanting to kill him. He decided that he wanted to go home following a visit by his mother and although staff tried to dissuade him from this course he left on 11 July 2002, being taken from the hospital by his father. His mental health was not sufficiently bad for him to be detainable at that stage. He went to his mother's despite ASW1's earlier contact with his aunt about his going to live with her.

For the remainder of 2002 he was supported in the community and given his depot injection when it was required with little disruption. He attended college for some

time. He displayed no signs of illness although during a visit on 6 November 2002 he admitted that he had not been taking his oral medication as often as he should have done. Despite that he was adamant that he had not been experiencing any symptoms.

Commentary

This period demonstrated good standards of care for Patient C who was closely monitored in the community, regularly saw his consultant and received his depot injection. When his health deteriorated there was an appropriate and rapid response resulting in his re-admission to the YPU. This followed the first instance of non-compliance with oral medication and should have been noted as a warning for the future in this regard. During the period Patient C's substance misuse was a problem and this was to become something of a recurrent theme. This had a variable effect upon his mental health. Patient C's mother, despite her own physical and mental health problems, proved to be a reliable reporter of developing problems and those reports, at this stage, were acted upon appropriately. Following Patient C's discharge on 11 July 2002 Consultant 1 sent an Inpatient Discharge Notification to Patient C's GP copied to ASW1 which stated that a full discharge summary would follow. The panel was unable to find any such full summary. In due course Patient C's next consultant, Consultant 2, sought a copy of the discharge letter but informed the panel that she did not receive it.

January 2003 to December 2004

By 7 January 2003 his mother was becoming concerned that Patient C was mixing with a drug-using peer group and was worried about his illness re-emerging. The possibility of involving the assertive outreach team (AOT) was considered, although never ultimately acted upon. Despite his mother's concerns Patient C continued to appear to be symptom-free. On 10 March 2003 ASW1 wrote to Consultant 1 updating him on Patient C's progress prior to a planned CPA review on 3 April 2003. On 27 March 2003 he admitted that he had taken small amounts of drugs in the preceding weeks but ASW1 could discern no positive signs of any psychosis. The review took place on 3 April 2003 when Patient C confirmed his cannabis use and was strongly counselled against this by Consultant 1. At this time consideration was

being given to moving his management from the young people's services to adult psychiatry. Consultant 1 wrote to Patient C's GP and ASW1 liaising with them as to the identity of the appropriate adult psychiatrist to take over Patient C's care and Consultant 2 was identified.

By 22 May 2003 Patient C had decided that he no longer wished to have his depot injection but at a meeting at the outpatient clinic on 30 May 2003 with Consultant 2, who had become his consultant psychiatrist, he was persuaded to accept a depot injection of a different medication, Piportil. During a home visit on 11 June 2003 he appeared to be well despite recent stressors in his life, including his mother being briefly admitted to hospital. In a report dated 18 June 2003 Consultant 2 gave a diagnosis of schizophrenia with Patient C's current treatment regime being 100 mg Piportil monthly, 10 mg of Olanzapine each night and 5 mg Procyclidine as required. A positive picture was painted at another home visit on 25 June 2003.

There was another brief visit to the house on 22 July 2003 when ASW1 arranged to see him the next day for a review with Consultant 2. When ASW1 attended the next day he was informed by Patient C that he could not keep that appointment as he had to go to court in relation to an incident the previous week during which he had injured a young man. In fact he did not go to court as he revealed on a subsequent visit on 28 July 2003.

ASW1 arranged to come back the next day when it was hoped that more information about the court situation would be available. During that home visit, on 29 July 2003, Patient C revealed that he had not been taking his Olanzapine for about one year. ASW1 wrote to Consultant 2 on 1 August 2003 giving a full report and seeking her advice in relation to Patient C's medication. Patient C continued to be given his depot injections, although from time to time there were difficulties with his not being in and, on one occasion, his not having collected the correct medication for it to be administered.

A review was arranged for 17 September 2003 but Patient C had forgotten about it and initially could not be located. When ASW1 did find him it was clear that he had taken some drugs and he said that he had used amphetamine. The review went ahead and, under the influence of the amphetamine, Patient C was much more

forthcoming about his drug use than he had been previously. He admitted that he had been using amphetamine on a fairly regular basis and suggested that it made him more talkative and confident and that he was anxious and troubled when he did not take it. He reported a very disturbed sleep pattern but would not accept that was due to the effects of the amphetamine. He was warned about the possible dangers in relation to his mental health of taking amphetamine but said that he had not experienced any such symptoms over a three-year period, in contrast to what had happened when he took cannabis. It was agreed to give a trial of Trazodone and that Patient C's case would be kept under review by Consultant 2 and ASW1 at the regular team meeting on 26 September 2003. On 24 September 2003 Patient C committed an offence of assault occasioning actual bodily harm against a 17-year-old male victim. In relation to that offence he was given a conditional discharge on 8 January 2004.

His lifestyle continued to be fairly chaotic, and there was a change of address in October 2003 with Patient C moving to Cramlington with his mother and sister. For the remainder of the year ASW1 continued to support Patient C accompanying him to court on a number of occasions and liaising with his mother. During this period Patient C was not recorded as displaying any signs of illness but on 4 December 2003 his mother informed CPN2 that he no longer wished to have his depot injections. On 14 January 2004 ASW1 reported to Consultant 2 on the events of the past months and was of the view that Patient C's involvement with the criminal justice system was the result of cultural and other issues as opposed to being linked to his diagnosis of schizophrenia. He said that Patient C was presenting as free from any positive illness symptoms and had improved energy and volition, good concentration, a positive sleep pattern, healthy appetite and was generally content with his situation at that time. He had not had his depot injection since November, having refused the December injection. ASW1 raised the question of a transfer of care from Consultant 2 to Consultant 3, because Patient C was now residing in Cramlington, but sought advice in relation to his refusal to take medication. ASW1 reviewed Patient C at his home on 16 January 2004 in the presence of his mother, when he found no change in Patient C's presentation from what he had last reported to Consultant 2.

On 16 January 2004 Consultant 2 responded to ASW1's letter that she considered that Patient C's care should be transferred to Consultant 3 but that prior to that she felt that she and ASW1 ought to review Patient C together in order to assess whether he was well enough to take the decision to withdraw from medication and to put a contingency plan in place. Prior to that review Patient C was accompanied to South East Northumberland Magistrates Court on 18 February 2004 by ASW1 and a student social worker when one of the assault occasioning actual bodily harm charges that he was facing was adjourned for four weeks because the injured party failed to appear. At court the student social worker noted that Patient C was having some odd thoughts, a broken sleep pattern and increased dreams. There was, however, no evidence of delusions or hallucination. The planned review was due to take place on 25 March 2004 but when ASW1 went to collect Patient C he refused to attend and was quite bad mannered towards ASW1 saying that he felt well and could not see the benefits of attending.

On 8 April 2004 Consultant 2, who had not actually seen Patient C since 17 September 2003, wrote to Patient C's GP, copied to Consultant 3, reporting on the situation and saying that Patient C had become much more open about his heavy drug use at the time of his earlier psychotic episodes. He had been medication free since November 2003 and had shown no recurrence of any psychotic symptoms. He wanted help to find a place of his own but did not want any medication at that time. He did not think he needed to see a psychiatrist regularly at that time but was willing to be transferred to Consultant 3 and the possibility of having an initial meeting with him was raised.

On 11 May 2004 ASW1 accompanied Patient C to the Magistrates Court when a charge of assault against him was dropped because witnesses failed to attend. He was unwilling to attend the planned review with Consultant 3 and, two days later on 13 May 2004, said that he would not attend his CPA review as he felt he was not ill. He reluctantly agreed to occasional visits by ASW1. His mother reported that he was well in late May 2004. Over the summer there were a number of abortive home visits and he was not seen by ASW1, or any other mental health professional. On 12 June 2004 he committed an offence of theft from the person and on 11 July 2004 he was involved in an incident at a public house in Cramlington which resulted in a charge of

threatening behaviour. On 11 August 2004 ASW1 wrote to Patient C informing him that, in view of the lack of contact, he would discharge him from his caseload if he did not hear from him within one month.

On 21 October 2004 Patient C's mother contacted the GP practice on an urgent basis as she felt that Patient C was deteriorating. He had been low and depressed and was hearing voices. There had been a gradual deterioration over some months and although Patient C had been in denial about the symptoms he was now asking for some help. He had smashed his TV and was complaining about seeing things pass by and voices from the TV all day. An appointment was made for him on 25 October 2004 but he did not attend and, the next day, a locum GP made a home visit seeing Patient C at his girlfriend's address. He denied any visual or auditory hallucinations and said that he simply felt low, but was not suicidal. On 28 October 2004 GP2 wrote to Consultant 2 setting out the fact that Patient C had stopped taking his medication and that symptoms had returned, stating that he was keen to see a CPN but GP2 thought that he ought to be referred to Consultant 2 in the first instance. ASW1 wrote to Patient C on 5 November 2004, having attempted to see him earlier in the week, and offered a home appointment on 17 November 2004, or alternatively if Patient C preferred it, an office based appointment. Patient C came into the office on 11 November 2004 with his then partner and her two children. He maintained that he was well and the interview revealed no signs or symptoms of illness, although it was clear that there were a number of stresses in his life at that time. They were requesting housing advice, appropriate enquiries were made and it was confirmed that they were already receiving such advice.

On 19 November 2004 Patient C's mother called the CMHT and spoke to the duty worker, SW1, informing him that Patient C had agreed to take medication for his mental illness and asking if ASW1 could provide some. She was advised to contact the GP and did so, obtaining a prescription for Olanzapine tablets. On 23 November 2004 Patient C's care plan was noted as his having withdrawn from services, although the file was kept open and he was to be offered an appointment with Consultant 3 - doubt being expressed as to whether he would attend. On 25 November 2004 Patient C's partner called the CMHT saying that Patient C wished to speak to somebody, but not ASW1. On 30 November 2004 ASW1 wrote to

Consultant 3 setting out the history and commenting that at that time it was difficult to see any evidence of mental health illness relapse. On that same date Patient C was written to and offered an appointment with Consultant 3 on 16 December 2004.

It seems that at this time Patient C and his girlfriend were experiencing problems at the hands of her ex-partner. Simultaneously Patient C's solicitor was expressing concerns about some forthcoming court appearances related to his offending earlier in the year and wrote to ASW1 enquiring as to the identity of the psychiatrist who Patient C was due to see, raising the possibility of obtaining a report for court purposes. This prompted ASW1 to write to Consultant 3 in which letter he queried whether Patient C's willingness to engage with services was motivated by a desire to mitigate the consequences of court appearances. By 14 December 2004 Patient C was in Darlington and registered as a new patient with a GP in that area. He failed to attend an appointment with his Cramlington GP on 15 December 2004 and with Consultant 3 on 16 December 2004. This may well have been because he was in Darlington, but the next day his mother contacted both the CMHT and Patient C's GP surgery in Cramlington suggesting that he was "due to have a schizophrenic seizure" and expressing concerns about him. SW1 spoke to Consultant 3 and it is noted in the CMHT records that it was planned that GP1 would visit Patient C to assess him, but there is no record of such a visit taking place, nor of any information coming to the CMHT in relation to that proposed visit.

Commentary

There was no multi-disciplinary review of Patient C's case on the initial transfer from Consultant 1 to Consultant 2; although this was arranged Patient C failed to attend and the appointment that he attended on 30 May 2003 dealt with his refusal to accept his depot medication rather than his overall needs. There is no contemporaneous medical note of this appointment. The first full CPA review took place on 17 September 2003, although again there is no contemporaneous medical note of this. At this stage Patient C's needs were being considered with proper frequency, his concerns in relation to his medication responded to and his overall treatment was in accordance with policy. When it was indicated, on 4 December 2003, that Patient C would no longer accept his depot medication this was not communicated to Consultant 2 until 14 January 2004. Although Consultant 2 responded promptly and appropriately to this being raised no full review was arranged until 25 March 2004, by which stage Patient C had missed at least four depot injections. When Patient C refused to attend the appointment on 25 March 2004 the panel is of the view that there ought to have been a formal review of his case with Consultant 2 and ASW1 considering it together and deciding on the best way forward. The management of Patient C's case – who was on enhanced care co-ordination and had a diagnosis of schizophrenia - was beginning to drift. This drift continued with Patient C being written to on 11 August 2004 and informed that he would be discharged from the caseload of ASW1 if he did not hear from him within one month but there is no record of this being acted upon as indicated. The panel is of the view that it would have been better practice either for a decision to have been taken to discharge Patient C formally at that point or to take more active steps to re-engage him with the CMHT.

Patient C's mother's reporting of his symptoms and references to her fears of a relapse were not given the weight and attention that they previously had been. The panel found it surprising that when in October 2004, there were reports indicative of psychotic symptoms and an indication of his willingness to engage with the services that his file was noted as his having withdrawn from services on 23 November 2004. The panel believes that this represented an opportunity to re-assess Patient C's case and fully to re-engage him, if appropriate. Equally, when his mother again

reported her concerns on 17 December 2004 and it was thought that Patient C was to be seen by his GP but no report came back to the CMHT, the panel is of the view that there ought to have been follow up.

The panel notes that this period denotes a subtle but significant change in emphasis from the need to support a young man with a diagnosis of paranoid schizophrenia, to one whose issues were related to lifestyle choices, including the use of drugs and involvement in low level criminality, and whose management therefore was more on a social care model. This was evident from ASW1's communication with Consultant 3 questioning Patient C's motivation for re-engaging with mental health services, which was confirmed in ASW1's oral evidence.

January to February 2005

On 25 January 2005 Patient C's mother requested an MHA assessment and he was seen that night at his mother's home in Cramlington by the duty consultant psychiatrist and ASW 2 and admitted to Otterburn Ward of St George's Hospital, Northumberland at 23.30hrs. There is a contradiction between the record of this assessment and the notes of his admission in that he is initially noted as 'not drunk' but on admission it was said that he had consumed a bottle of vodka prior to attending the ward and was too intoxicated to be assessed, becoming aggressive and threatening towards the doctor conducting the interview. He was transferred from Otterburn Ward to Delaval Ward and seen by Consultant 3 who found no signs of mental illness and was of the view that it was not helpful to have him admitted when he was intoxicated and that there was no need for outpatient follow-up. He displayed no signs of disturbance whilst on the ward and was to be discharged the next day. There were no problems during the rest of his stay in hospital and he was duly discharged. A discharge letter to GP1, by SHO1 dated 1 February 2005 and countersigned by Consultant 2, refers to a diagnosis of acute intoxication due to alcohol and his previous history in 2001 is incorrectly referred to as his having been assessed on an outpatient basis and that he had been diagnosed with a psychotic illness associated with substance use. The letter also incorrectly refers to his current admission as being his first inpatient period.

A discharge plan held with the medical notes incorrectly refers to Patient C being on standard CPA and states that no formal follow up is required.

Commentary

The report of ASW2 sets out information from Patient C's mother and observations by the duty consultant psychiatrist that were indicative of a psychotic relapse and referred to his previous admission to the YPU. The discharge letter appears to have been based simply on his presentation on Delaval Ward and failed to take into account the evidence of the report of ASW2. The previous diagnosis and admission to the YPU were correctly recorded in the nursing notes on Otterburn Ward but that information appears not to have been taken into account in the discharge letter.

Given the evidence that had been present on Patient C's assessment and his mental health history, the panel is of the view that it was inappropriate to conclude, after less than 24 hours observation, that he could be discharged with no formal follow up.

February 2005 to July 2006

On 29 March 2005 it was recorded that Patient C's mother had contacted the crisis assessment and intervention service (CAIS) reporting that Patient C was unwell but that things seemed to have calmed down somewhat. On 20 April 2005 ASW1 wrote to Patient C's GP informing him that Patient C had been discharged from his caseload after a lengthy period of non-contact and a meeting with Consultant 3 in November 2004. At this time Patient C was having considerable contact with the criminal justice system appearing on 4 May 2005 and being fined and, on 14 May 2005, committing a series of road traffic offences. This resulted in his being remanded in custody. On 31 May 2005 Patient C's mother requested that his mental health be assessed whilst in prison. After an initial failed attempt, he was seen on 9 June 2005 and informed the clinical nurse specialist, Specialist Nurse 1 that he was currently on the caseload of Consultant 3. Consultant 3's secretary was contacted to fax the relevant information to the prison. He was kept under review whilst in custody and on 22 June 2005 was reported to be well settled with no distressing psychiatric symptoms.

On 28 June 2005 Patient C appeared at the South East Northumberland Magistrates Court and was sentenced to a 12 month community order with conditions of supervision and that he complete the Think First programme. During the summer of 2005 Patient C appears to have had no contact with the mental health services but committed a series of offences. On 16 August 2005 he stole jewellery from his sister and two days later, when he should have been keeping a supervision appointment, he failed to do so and assaulted both his mother and his sister. He was charged with those offences on 19 August 2005 and Probation Officer 1, who was allocated his case, sought his permission to access his medical records on 26 August 2005.

Patient C should have attended court on 2 September 2005; he failed to do so but did appear on 15 September when his case was adjourned for a week and he was bailed to reside at a hostel in Blyth. He next appeared before the court on 22 September 2005 when his case was adjourned. Later that day he committed another offence of battery. As a result he was arrested, appeared in court the next day and was remanded in custody to 14 October 2005.

Patient C's mother again contacted the prison services on 26 September 2005 informing them of his previous diagnosis of schizophrenia and suggesting that he had recently relapsed and asking that steps be taken as Patient C himself would be unlikely to approach anybody in relation to this matter. He was seen on the wing on 3 October 2005 by the Mental Health In-reach Manager, who subsequently reported that Patient C had at first been denying any strange/bizarre occurrences but then admitted that he was hearing things and receiving messages from the television and/or radio. He was not distressed by these but became anxious during the interview, relaxing when it was explained to him that this was an information gathering exercise and that there was no plan to send him to hospital.

On 14 October 2005 Patient C was sentenced to a community order for 18 months with a supervision requirement. He failed to attend a number of supervision appointments with the probation service but on 24 November 2005 was taken by his mother to the GP's practice where he was seen by GP2. The doctor received contradictory information as his mother said that Patient C attacked her and her daughters, said strange things and laughed inappropriately, whereas Patient C denied saying strange things, said that he was not hearing voices and denied any

first rank symptoms. The doctor decided that there were no obvious features from which to make a diagnosis and it was not appropriate to refer him to the CAIS or a psychiatrist. The doctor discussed the case with CPN3 (attached to the GP practice) and an appointment was sent out to Patient C for 29 November 2005 but he failed to attend. He also failed to attend an appointment on 14 December 2005 that had been arranged by his mother. He had attended at the Magistrates Court on 6 December 2005 but failed to do so on 5 January 2006 when a bench warrant was issued for his attendance. He duly appeared on 12 January 2006 when he was granted conditional bail and the case was adjourned to 2 February 2006 for the preparation of a pre-sentence report. On that date the magistrates requested a psychiatric report be prepared and the probation service was requested to organise that. That request resulted from Probation Officer 1 having raised, in her report to the court, her own concerns about Patient C's current mental health. He breached his bail and was remanded in custody on 18 February 2006.

In prison he was observed to be acting strangely and was expressing odd thoughts; a note on 25 February 2006 said that he should be seen by a psychiatrist as soon as possible. On 27 February 2006 he was seen by CPN4 (an inreach worker at HMP Durham) and was again expressing bizarre thoughts. CPN4 set out a four point plan including a requirement for medication and chasing up the referral to the psychiatrist. At an appearance on 2 March 2006 he was further remanded to 23 March 2006 on which date CPN4 contacted the CMHT concerned about Patient C's mental health as he was claiming that his mother was not his mother, that she had been killed by her father and that his real mother was a woman called SM. On that same date he was bailed by the magistrates with conditions of reporting, which he immediately breached and he also failed to attend an offered appointment with his probation officer. He failed to keep his appointment with Consultant 3 on 30 March 2006 and a further appointment was sent for 13 April 2006. He was again arrested for failing to report to the police station on 12 April 2006 but re-bailed whereupon he failed to attend the appointment that he had been offered on 13 April 2006 and assaulted his sister the next day. He was arrested in respect of that offence on 25 April 2006 and remanded in custody.

On 5 May 2006 he was seen by CPN4 in HMP Durham and was noted to have flight of ideas and, although he denied having hallucinations, he thought that his mother and father were not his real parents. He was laughing inappropriately. On 8 May 2006 he was sentenced to 4 months imprisonment (which had the effect of terminating his involvement with the Probation Service). He did not attend a prison inreach appointment on 11 May 2006, stating that he was cured. On 18 May 2006 the CMHT records show him as having failed to attend three times and discharge was considered. It seems that the CMHT were unaware that he was in prison at that stage. On 19 May 2006 he was reported to be 'doing okay', not on any medication but sleeping and eating all right. On 23 May 2006 he smashed his TV in his cell having mis-read a letter in relation to his sentence but he displayed no evidence of psychosis. During the remainder of his time in custody he was noted to have flight of ideas and pressure of speech but denied hallucinations or delusions.

There were concerns about the safety of his mother and sisters upon his impending release in view of his violence towards them. A member of the children's services team in Blyth contacted the prison but was informed that as Patient C would not be on licence the prison could offer little help. On 1 June 2006 as a result of the concerns of the member of the children's services team a Multi Agency Public Protection Arrangements (MAPPA) referral was made by a prison probation officer in HMP Durham. It was considered by Assistant Chief Probation Officer 1 but was declined on the basis that Patient C did not fit the criteria. He was not seen in prison by a psychiatrist until 3 July 2006 when he was noted to have delusions about his parents' and sisters' identities and was diagnosed as probably being schizophrenic. Efforts were made to arrange his transfer to hospital under section 47 MHA. The documentation for such a transfer was completed on 3 July 2006 but the transfer did not take place. Despite liaison between the prison and St George's Park Hospital there was no formal transfer but on his release date Patient C was taken by members of the CAIS directly to Newton Ward at St George's Park Hospital. He was admitted informally and his bizarre behaviour in prison was noted and attributed to a relapse of his schizophrenia; he was prescribed Olanzapine.

Commentary

This period is largely characterized by the chaotic life style that Patient C was leading and his offending which led to a series of remands in custody and ultimately the four months prison sentence. It is noteworthy that at the beginning of the period the confused management of Patient C continued. In April 2005 GP1 was written to, the letter referring to a discharge meeting in November 2004. It was noted by the panel that there is no record of a discharge meeting in November 2004, the records relate to a review meeting on 23 November 2004 with a further review planned for 23 January 2005. Although the letter to the GP states that there had been a lengthy period of non-contact, the reality of the situation was that there had been several instances of contact as well as the in-patient admission in January 2005. Throughout this period symptoms of mental illness were noted on a number of occasions, notably by his mother, Probation Officer 1 and prison mental health inreach staff. Efforts to address this were hampered by Patient C's failure to keep appointments but a lack of awareness of his whereabouts led to the CMHT having the impression that there were more failures to attend by choice than was actually the case, as Patient C was unable to keep some appointments as a result of being remanded into custody. Despite marked concerns about his mental health and repeated references in his prison medical records to the necessity for him to be assessed by a psychiatrist this did not happen until just before the end of his sentence. This led to a hurried and unstructured transfer to St George's Park Hospital. Had he been seen earlier then it is possible that the attempt to transfer him to hospital under section 47 MHA might have been successful, which would have affected how his case was dealt with subsequently. No satisfactory explanation was provided to the panel in relation to the delay in Patient C being seen by a psychiatrist whilst in prison. Having heard the evidence of Assistant Chief Probation Officer 1 the panel was satisfied that the MAPPA referral was dealt with appropriately.

July 2006 to August 2006

Patient C remained on Newton Ward from his admission on 7 July until 31 July 2006. On 8 July 2006 there was no evidence of delusional ideas or any psychotic symptoms noted. A urine sample was taken for drugs screening and in due course

was reported as being negative. On 11 July 2006 ASW1, who visited him on the ward, thought that he was still experiencing strange thoughts which Patient C described as "racing away" and said that his teeth looked strange in the mirror. On occasions over the following days he was noted to be laughing inappropriately, he still believed that his aunt was his real mother, his behaviour appeared somewhat bizarre and he was agitated at times and "speeded up". He talked of his mother and became agitated when doing so and described previous violence involving cutting someone's ear and felt that his mother "drowned him". There was some sexual disinhibition and at times he was tense and angry. ASW1 reported a conversation with his mother in which she suggested that he had been unwell for some months, making suggestions that his sister and mother were not real and that it was alright to sleep with his sister as she was not really his sister. Throughout his time on Newton Ward the nursing and clinical notes reveal someone who was recognized to be mentally unwell and Consultant 4, who had his care at that time, was clear that Patient C had suffered a significant relapse of his schizophrenia.

On 31 July 2006 he was transferred to Embleton Ward and is recorded as being settled and appropriate over the next few days. On 7 August 2006 he described to SHO 2 having assaulted a fellow prisoner by stabbing him in the neck with a pen. A care plan review was held on 9 August 2006 in which ASW1 reported that the family insisted that if Patient C was to go home then he had to be on a depot injection, as they had no faith in oral medication given Patient C's previous history of non-compliance. Patient C admitted to hearing a voice external to his head, which sounded like his own, but told him to do things. He was willing to have a depot injection if his consultant and the team thought it the best option. He was recorded by SHO 2 as still being psychotic at that time.

Within the next week, following the transfer, the clinical picture presented in the notes changed considerably. Patient C was anxious about a forthcoming visit from his father but relieved when it went well. He began to deny hearing voices or having delusions about his mother and said that he only said those things in order to "get people off his back". He was frustrated about being in hospital, did not feel that he needed any medication and by that time was unwilling to have a depot injection.

Consultant 3 recorded, on 15 August 2006, that there was no evidence of any mental illness on interview.

On 17 August the circumstances of his admission were noted by SHO 2, including his presentation in prison and on Newton Ward. At the end of an entry it was recorded that there had been no clear evidence of psychotic features whilst on Newton Ward. SHO2 identified the issues as being his behaviour, with a query raised about his being a risk to others, the need for further assessment of his mental state and housing. Later that day an incident occurred on the ward when Patient C came out of the toilet and had either spilled some water or dribbled urine on his jeans (the medical notes refer to his having dribbled urine but Patient C was later to tell Consultant 2 that he had spilled water). At that time he noticed some members of staff laughing, which he interpreted as being directed at him. This caused him to become very angry and he went into the lounge and threw a table at a unit, overturned the bookcase and smashed some plant pots. Consultant 3 recorded that whilst there appeared to have been some symptoms of mental illness on his admission they were not present at that time and his presentation suggested a young man with an impulsive, explosive personality disorder. His current level of symptoms did not warrant in-patient care and whilst a planned discharge would have been preferable, he posed a risk to staff and patients and was to be discharged that evening. The police were present and were expected to charge Patient C and the discharge plan was to inform the community team and, if he was remanded, ask for services to follow him up in prison. He was to be provided with one day's supply of medication, the nursing staff were to inform the community team of his discharge and to liaise with the police and his medical discharge needed to be completed as soon as possible and faxed to the prison if he was detained there.

The discharge summary, dated 18 August 2006, gave a differential diagnosis of: mental and behavioural problems due to substance misuse; paranoid personality trait; previously diagnosed with schizophrenia. It was reported that he expressed bizarre and violent behaviour which was mainly due to misinterpretation of actions of others and there was no clear link between his violent behaviour and psychotic symptoms.

Commentary

The panel is of the view that Patient C's treatment whilst on Newton Ward was appropriate and consistent with his presentation and history. There is documented evidence of psychotic phenomena whilst on Newton Ward. There are fewer such entries in the records from Embleton Ward and there is one misleading entry, by SHO2, of there having been no clear evidence of psychotic symptoms whilst on Newton Ward. The panel noted this change of emphasis and is of the view that this may have influenced the manner of his discharge and follow up arrangements.

The panel regards the discharge of Patient C as being unsatisfactory. Patient C had had a relapse of his paranoid schizophrenia in prison necessitating his admission to hospital. Symptoms of the relapse were still present in hospital and required active treatment. The panel is not satisfied that this was properly reflected in the discharge summary. In the light of the previous diagnosis of schizophrenia both historically and on Newton Ward the panel regard it as surprising that Patient C's paranoid thinking in relation to the incident leading up to his discharge was regarded as evidence of a paranoid personality trait rather than of paranoid schizophrenia. There was no proper discharge meeting to consider an appropriate care plan for Patient C either before or subsequent to his discharge. There was an obligation on the ward team to ensure that a proper CPA meeting was held. Given the uncertainties surrounding what was to happen to Patient C upon his discharge, that obligation was all the greater. Although the discharge plan recognised the need for follow up, whether by the community team or in prison, little indication was given as to the nature of the patient's needs or ongoing care requirements. The discharge letter failed to reflect the clear psychotic relapse that he had suffered. Furthermore the panel is of the view that the differential diagnosis at the point of discharge, emphasising personality issues and substance misuse, was misleading given the evidence gathered during the admission. The letter also records that Patient C had been provided with medication on discharge for one week, whereas the notes indicate that he was given a supply for only one day.

August 2006 to 15 July 2007

As expected, following his discharge, Patient C was charged with criminal damage and appeared at the Magistrates Court on 18 August 2006 and was given a three month conditional discharge for the offence of criminal damage the previous day. The CMHT duty worker was in attendance at the Magistrates Court and gave Patient C a week's medication.

ASW1 undertook a home visit on 21 August 2006 when Patient C was seen at his aunt's home with his mother in attendance. An informal support package had been developed by the family with Patient C to reside between his aunt's, his mother's and his grandmother's homes but in the long term he was looking to find his own accommodation. It was agreed by all that Patient C needed to keep on with his medication of Olanzapine. There was a discussion about safe and social behaviour with Patient C expressing the fact that he was aware that he must keep his temper under control and that the medication was of benefit in that regard. There was no evidence of delusional thought patterns or any bizarre behaviour. The plan recorded on that occasion was to reassess Patient C's community behaviour and illness following the completion of ASW1's leave (which he was about to embark upon) and to refer Patient C to the AOT in the light of his history and probable needs. A note was placed on the file that if problems arose and a crisis developed in the home, workers should not attend an emergency situation alone because of previous violence. Although Patient C had no history of assaulting professionals they should consider having a police presence if he was reported to be unwell or volatile.

ASW1 sent off an application for Patient C to the Byker Bridge Housing Association (BBHA) which was duly acknowledged. On a home visit on 19 September 2006 all seemed to be well although his mother reported that he had voiced some strange ideas of possible communications from God when he was half asleep or tired. Patient C himself felt that it was his old illness playing up but he had not been distressed by this and recognised that his previous feelings about his family not being real or imposters had been when he was unwell. Patient C was happy to continue on his prescription of Olanzapine and was experiencing no side-effects. He

agreed to meet ASW1 the next week to create a formal care plan and receive risk management advice.

On 29 September Patient C was taken by ASW1 to accommodation in Blyth provided by BBHA in view of a possible placement becoming available. He presented very well and was keen to make moves towards supported living and appeared to have improved insight and trust in his medication and the support services. A home visit on 19 October 2006 was satisfactory with Patient C remaining settled and well, although he described a brief period of paranoia when he thought that strangers in the street had been looking at him. This had occurred when he went for three days without his medicine, because he had forgotten to obtain a new prescription for his Olanzapine. Patient C stated that this had given him clear evidence that he needed to take the Olanzapine in order to stay well. A formal care co-ordination plan was completed on 19 October 2006 with an action plan if any risk factors began to show themselves. This placed Patient C on enhanced level of CPA. He was registered for care co-ordination on 25 October 2006.

On that date Patient C is said to have met with Consultant 2 and ASW1 but there is no record of this meeting. On 30 October 2006 Patient C received notification that he had been accepted by BBHA and placed onto a waiting list, to be contacted as soon as a suitable vacancy arose. On the same day ASW1 completed an application form for Disability Living Allowance (DLA). That form contains a full account of Patient C's mental health referring to a diagnosis of schizophrenic illness with paranoid belief systems, stating that he had daily medication, consultant psychiatrist support and care co-ordination community support. A major period of relapse in summer 2006 leading to an extended period in hospital is referred to. It states that relapse is evidenced whenever Patient C was unsupported and the prognosis was said to be that he would need long term assistance and management of his psychotic/schizophrenic type illness, with medication and professional supports required to maintain reasonable and safe social functioning. He required a full programme to support independent living.

The final months of 2006 proceeded relatively uneventfully with ASW1 visiting with regularity and supporting Patient C in the community. On 15 January 2007 a

vacancy arose at BBHA accommodation which Patient C was able to take up immediately. On 19 January 2007 his position was reviewed at that accommodation with the residential support worker and ASW1 and the situation was entirely positive with Patient C appearing to retain insight into the benefit of his medication and happy to abide by the BBHA rules. Over the next months attempts were made to continue to support Patient C and he became involved with a voluntary agency (Developing Initiatives, Supporting Communities) and began to have Cognitive Behavioural Therapy (CBT) sessions with ASW1.

A care co-ordination plan review on 30 April 2007 was attended by Patient C, ASW1 and the residential support worker at the BBHA accommodation. The review was positive and suggested that at that time Patient C was well without evidence of major anxiety, stress or vulnerability to illness symptoms and had insight into the value of his Olanzapine and its role in assisting with psychotic issues.

However, shortly after that when the DVLA wrote to Patient C's GP, GP1, to obtain a report as to his fitness to hold a driving licence a very different picture was presented. He was seen by GP1 who produced a report dated 7 June 2007. The report indicates that Patient C's mental state was so unstable and that he lacked insight to such a degree that driving would be dangerous. It also states that he had stopped taking his medication at the end of April. It records that he had significant lack of judgement and raises a question about alcohol dependency suggesting that he had persistently misused alcohol (but not drugs) in the past 12 months. In response to the question 'Is there any other medical condition that may affect safe driving?' GP1 ticked the 'Yes' box and stated 'has history of psychosis, intoxication of alcohol and substance misuse'.

In contrast to the concerns expressed in the DVLA report, the record of a meeting at the BBHA accommodation between ASW1, the residential support worker and Patient C on 21 June 2007 was almost entirely positive, save for Patient C not wishing to have a CBT session. It concluded 'No risk behaviours noted denies any harm thoughts/plans when asked directly. Continue plan, skills of independence and forward into training reactivation'. A further visit on 4 July 2007 was similarly positive with ASW1 concluding that overall Patient C appeared well, with laughter and

generally relaxed presentation, clear concentration and thoughts. There were no negative entries until 16 July 2007 when the fatal incident occurred.

Commentary

This period leading up to the death of Victim C appeared, superficially, to be going reasonably well in that according to the CMHT records Patient C had moved into supported accommodation, was apparently concordant with medication and making progress. The circumstances of Patient C's discharge on 17 August 2006 and the lack of a proper discharge meeting resulted in there being extremely limited medical input and ASW1, in his own words, being "left to pick up the pieces". The discharge letter of 18 August 2006 was accepted as a referral to the CMHT but, with no MDT meeting taking place, the decision to register Patient C on enhanced level CPA appears to have been a unilateral decision by ASW1. The first care co-ordination meeting took place on 19 October 2006 and Patient C was not registered on CPA until 25 October 2006. Until that time there had been no multi-disciplinary input. The meeting between ASW1 and Consultant 2 on that date was the first such meeting and there is no contemporaneous record of this. No satisfactory explanation as to the absence of any record was given to the panel.

The panel is of the view that the DLA application form is full and accurate in its account of Patient C's history, mental health and ongoing care needs. Although both the care co-ordination plan of 19 October 2006 and the DLA application describe the care package required, the reality of the situation was different. During this period ASW1 was the only mental health professional regularly seeing Patient C and was effectively managing his case alone, on a purely social work basis. Had there been others involved, it might well have been the case that the very different picture observed by GP1 would have been noted and appropriate steps taken to address the problems identified by GP1. The panel is of the view that GP1's observations and concerns ought to have been brought to the attention of the CMHT.

Throughout the entire period of his involvement with secondary mental health services, after Patient C moved from young person's to adult services, there was a failure properly to comply with CPA policy in that there were no regular CPA reviews. When Patient C was disengaging, his case was allowed to remain nominally active,

whereas had he been formally discharged and then properly taken back on there would have been a full review of his case at that time. When he was taken back onto the case load of the CMHT after his discharge in August 2006 no proper discharge meeting took place to develop an overall care plan for his future. Patient C remained subject to S117 MHA care throughout the period after his initial discharge from the YPU until the death of Victim C but this was lost sight of by the CMHT and this may have contributed to his earlier clear diagnosis being somewhat overlooked at times.

Events following killing of Victim C

After the death of Victim C, Patient C was questioned by the police and remanded in custody before progressing through the criminal justice system to ultimate disposal with the sentence of 4½ years imprisonment imposed on 15 September 2008. For the court process he was seen by four forensic psychiatrists who reviewed his history and provided reports relating to his mental state at the time of the offence and at the time of reporting. There was uniformity of opinion that Patient C suffered from paranoid schizophrenia from a young age. Although one author was of the opinion that Patient C's paranoid schizophrenia was in remission at the time, the other three reports took the view that his paranoid schizophrenia may have played some part in the commission of the offence.

Commentary

The post offence reports confirm what, in the view of the panel, the evidence available throughout the period being reviewed demonstrates, namely that Patient C suffered from paranoid schizophrenia, which was in remission from time to time, but always a factor present in the background. That was not sufficiently recognised by all of the professionals involved in his care, after his initial involvement with the young people's services, and ultimately led to Patient C's case being managed on a social care basis rather than on a truly multi-disciplinary basis.

Overview of Psychiatric Care

Patient C's psychiatric presentation and care can be conveniently broken down into four distinct phases:

- his initial psychiatric presentation and stabilisation of his symptoms
- transition into adult services and his gradual disengagement
- relapse in prison and transfer to hospital
- maintenance in the community up until the index offence.

Background

Patient C was born on 26 November 1984 in Cramlington, a town in the North East of England. He has two younger sisters. There is no evidence to suggest any difficulties in the perinatal period or delayed developmental milestones in the first five years, though there were only limited contemporaneous records of his early years available to the panel. Up until the age of 13, he lived in the family home with his mother as the primary care-giver.

He attended state-funded mainstream schools. He reported to a number of professionals that at school he would get caught up in fights, set at least one fire, was regularly in trouble and had one period of being excluded due to drug use. He was not a member of any youth organisations, but was a keen footballer. He self-reported being popular and not a loner. He left formal education aged 16, without sitting any examinations.

His birth father was reported to have been a builder and manual labourer. His father left home when he was aged approximately eight, but Patient C reported that he retained a good relationship with him, though contact was infrequent and irregular.

There is a family history of mental illness, with schizophrenia reported in a second degree relative and a first degree also known to mental health services – although not having schizophrenia or a related illness.

Reports indicate his upbringing to be unsettled, with interpersonal violence being a feature of his mother's relationship with both his birth father and step-father. There

were also reported familial pro-criminal behaviours, with the suggestion that his stepfather would often be absent from the home because of this. There is no evidence in the record of him experiencing direct physical abuse or sexual abuse; however he reported to have been physically disciplined by his natural father.

He reported that at about age thirteen, his stepfather set fire to the family home, and this, with subsequent targeted violence, led to his mother moving to a women's aid shelter and Patient C living with relatives.

Patient C has had two significant intimate relationships. The first, when he was aged sixteen was to a similarly aged girl. She had a termination of pregnancy during their relationship, with which he found difficulty coming to terms. His second relationship was when he was aged nineteen to a woman three years older. They were together for three years, and at one point were engaged, however he reported her as having drug problems and he left her. He has no children to his knowledge.

Patient C has experienced little in the way of formal employment in his life.

Initial presentation and subsequent management in young people's services

Patient C first became known to mental health services in January 2001 aged 16 when he presented with florid symptoms of a severity, and associated with sufficient risk, to warrant admission into hospital. However it is likely that he had been experiencing prodromal symptoms for many months beforehand.

The prodromal period involved isolating himself from friends and family, and behaving in an increasingly odd way, such as locking himself in the house, taking apart radios as he believed them to be bugged, storing weapons in his room such as hammers and knives, throwing garden furniture at taxis, selling his clothes in case he was recognised, and believing if he saw scissors or screwdrivers he would be harmed. There was a known history of cannabis use and alcohol consumption during this time.

As well as these signs, there was a history of violence against family members, which included hitting his uncle over the head with a plant pot causing a wound that

required 20 stitches, slapping his mother across the face and episodes of verbal abuse towards family members.

Patient C was admitted to the YPU on 26 January 2001. There were a range of symptoms in his initial presentation, with him experiencing auditory hallucinations (hearing the words 'stab' and 'die'), beliefs that the television and cars were sending messages to him, visual hallucinations including seeing horns on his head in the mirror, vampires and his father turn into the devil, delusions of grandeur believing he was the chosen one, delusions of being controlled by white blood cells entering through a scar on his chin, and disordered thought processes.

He was initially admitted as a voluntary patient but, following repeated attempts to leave the hospital and showing an increasingly agitated state, he was detained under Section 5(2) MHA. This was converted to Section 2, which itself was later re-graded to Section 3.

During this admission he was commenced on regular antipsychotic medication. The initial response was poor, and there were compliance issues secondary to poor insight, leading to him being treated on a combination of oral and depot medication. At one point he was well above the recommended British National Formulary (BNF) dose of antipsychotic medication (20 mg Olanzapine plus 200 mg fortnight Haloperidol Decanoate depot, representing 166% maximum dose) but this was reduced due to drowsiness. He was discharged still on a relatively high dose, on a combination of both oral antipsychotic (Olanzapine 10 mg daily) and an intramuscular depot (Haloperidol Decanoate 200 mg fortnightly).

He eventually responded to antipsychotic treatment, and was formally discharged from hospital, following a period of home leave, on 14 May 2001 to his family home. His diagnosis on discharge was paranoid schizophrenia. There remained some impairment in social functioning upon discharge, and occupational therapy was involved to assist in increasing his confidence and independent living skills. He was also referred to the Cramlington CMHT. Psychiatric follow-up was with Consultant 1.

There were frequent reviews by Consultant 1 and a number of medication changes were instigated in response to, variously: residual symptoms; side-effects and

deteriorations in his mental health due to cannabis use. There were no reports of any problems with compliance with medication at this point. When issues of his illicit substance and alcohol consumption arose, they were actively addressed by the team with Patient C through psycho-education.

There was a second brief informal admission to the YPU on 4 July 2002, with him experiencing a relapse of auditory and visual hallucinations as well as ideas of reference. He admitted to having heavily consumed cannabis the weekend before with his uncle, and had not been taking his Olanzapine in the weeks preceding (he should have been on 5 mgs daily; he was still on his depot).

He was discharged on 15 July 2002 to his mother's home following a period of extended home leave. Although his positive symptoms had settled, some residual symptoms were again noted. He was discharged on Olanzapine 10 mgs daily, Haloperidol Decanoate 250 mgs every 4 weeks and Procyclidine 5 mgs twice daily.

Commentary

Patient C presented to adolescent psychiatric services with an early onset psychosis, which was managed through a combination of psychiatric and psycho-social interventions. This period demonstrated an overall good standard of psychiatric care of Patient C.

There were some elements of care however that fell below best practice. Although there was a brief medical discharge summary letter following the first admission, it did not provide a detailed account of his presentation, mental state, investigations, risk signature, risk management or prognosis. There was no full discharge letter from the second episode despite a letter stating that it was to follow. A detailed assessment of Patient C's initial presentation, triggers and risks and risk management was provided by CPN1 as part of her care co-ordination documentation completed in July 2001. However the lack of a full medical summary containing this information which could be carried forward into adult services may have contributed to later inaccuracies in his psychiatric history, and a failure to appreciate the nature of his schizophrenia and an underestimation of the risk and nature of any relapse.

It is noted that Patient C's total antipsychotic load on occasion exceeded BNF maximum. Exceeding the BNF maximum is permissible if a consultant considers that

the situation warrants it. The fact that the BNF maximum was exceeded may have been indicative of a severe and refractory psychotic illness.

Transfer to adult services and care 2003 to 2005

In 2003, aged 19, Patient C's care was formally transferred to adult services. The most significant aspects of this period up to 2005 is Patient C's increasing non-compliance with his medication regime, use of illicit drugs and eventual disengagement from mental health services.

Consultant 2 had received letters from ASW1, who by this point had taken over from CPN1 as care co-ordinator, in preparation for Patient C's consultant care transferring to her. The letters contain a reasonable summary, but Consultant 2 commented that it would be most useful to have a copy of the medical discharge summary. As noted above, it appears that none was received.

When Patient C's care was transferred he was on a combination of oral Olanzapine and depot Haloperidol, although it is not clear from the records why he was on a high dose of antipsychotic medication. Consultant 2 acknowledged that Patient C was a young man with a severe psychotic illness at the time of transfer, controlled by medication.

There had been some indication of medication non-compliance and illicit substance use prior to his transfer to adult services. Thus in late 2002 he admitted to omitting doses of his oral Olanzapine and in March 2003 he reported using cannabis. There was no evidence of relapse, with no positive symptoms noted in the period immediately running up to his transfer of care associated with these behaviours.

Patient C met Consultant 2 for the first time in her clinic on 30 May 2003. The week before he had apparently decided to stop his Haloperidol depot due to side-effects (he had started a sexual relationship and was experiencing weight gain, lethargy and sexual dysfunction), but at the clinic Consultant 2 persuaded him to change to a different depot; Piportil (Pipothiazine Palmitate). Following a test dose, he commenced his therapeutic dose of Piportil (100 mg monthly) on 12 June 2003.

On 29 July 2003, during a home visit, he told ASW1 that he had not been taking his Olanzapine for about one year. ASW1 immediately informed Consultant 2 of this, and the decision was taken that he would be maintained on depot medication. There were no indications that there was any relapse in his mental state. Consultant 2 viewed him as having a good degree of recovery, with no real residual symptoms and being "a little surprised" that there was no relapse after stopping his oral medication.

In September 2003, Patient C was reviewed whilst he was under the influence of amphetamines, which provided insight into more extensive drug use than previously appreciated. As he would not commit to reducing his amphetamine use, he was prescribed the sedative antidepressant Trazadone to help with his sleep, though he did not take it as prescribed and it was discontinued soon after.

In December 2003 he declined his depot Piportil, his last dose being in November 2003. From this point onward he was not on any antipsychotic medication. Consultant 2 wrote to ASW1 in January 2004 that Patient C should have a full review in the light of this. There was a planned review in March 2004 with Consultant 2, but Patient C refused to attend, saying he saw no benefit. As he had by this point changed address, Consultant 2 wrote to Consultant 3 regarding a future transfer of Patient C's care to him as the sector consultant. Consultant 2 noted that there had been no recurrence of psychotic symptoms, based upon the assessments conducted by ASW1. Patient C's mental health was judged to be stable, though there is an entry by SSW1 on 18 February 2004 that he was perplexed by some of his thoughts and had broken sleep.

Patient C did not attend the appointment with Consultant 3 on 13 May 2004 or his CPA review. In August 2004 ASW1 wrote to Patient C saying that in view of recent lack of contact, he would be discharged from his caseload if he did not hear from him in a month.

In October 2004 his mother contacted the GP practice, stating that Patient C had deteriorated, was hearing voices from his TV, which he had subsequently smashed. He was seen by a GP from the emergency out of hours service at his home, where he denied any psychotic symptoms. A practice GP felt it prudent to write to

Consultant 2 for a review as Patient C was not on any medication. Patient C, along with his girlfriend and her two children, was later seen by ASW1 on 11 November 2004, when no positive psychotic symptoms were noted. However his mother later contacted ASW1 saying that Patient C was now willing to take medication, and ASW1 provided advice as to how to obtain an Olanzapine prescription from his GP. It is not clear whether Patient C took any of the prescribed Olanzapine.

ASW1 wrote to Consultant 3 laying out the history, requesting he take over Patient C's psychiatric care from Consultant 2 and arranging an appointment for him to be seen on 16 December 2004. Patient C failed to attend the appointment. On 17 December his mother was concerned enough to contact the CMHT about Patient C's mental state, though no active follow up appears to have occurred.

On 25 January 2005 Patient C's mother requested an assessment under the MHA. At the time he was living with her and his two sisters. He was seen that evening by the duty consultant and ASW3. His mother reported him having similar symptoms to 2001: with physical violence towards her; verbal aggression and verbal insults; being hyperactive; having fast speech; being more mistrustful and less affectionate and behaving in a weird way. ASW3 reported that in conversation with Patient C there was pressure of speech, a salad of ideas, and some grandiose ideation. A number of stressors were identified, including his girlfriend's pregnancy, his worries about her fidelity, and recent charges of assault.

Following the assessment, Patient C was admitted informally to Otterburn Ward at St George's Hospital, Northumberland, in the early hours of 26 January 2005 and discharged the following day. He was noted to have been aggressive and drunk on admission, and was found not to have experienced a relapse in his mental disorder. The discharge summary does not acknowledge his significant past psychiatric history in young people's services simply stating 'Possible history of a psychotic illness surrounding drug use in 2001'. He was diagnosed as having an acute intoxication due to alcohol and discharged with no follow-up. There is no mention of his previous diagnosis of paranoid schizophrenia.

Despite ASW1 stating his intention to discharge Patient C September 2004, he was not formally discharged until April 2005.

Commentary on the handover from adolescent to adult services

The handover between care co-ordinators (CPN1 to ASW1) provided a detailed description of events surrounding Patient C's illness. The fact that ASW1 was involved relatively early meant that there was good continuity of care as Patient C transitioned into adult services. The handover between consultants was less comprehensive, with no medical summary from consultant to consultant as Patient C made the transition to adult services, and there were key summary documents from his time in YPU that were not completed.

Commentary on this period of care in adult services

Clearly Patient C becomes increasingly more difficult to engage with during this period, though the care team does appear to have taken reasonable steps to mitigate this, such as persuading him to change depot medication rather than stop it, holding a CPA review at 6 months (September 2003) and offering repeat appointments when he failed to attend.

Patient C was using amphetamine during this period, which was discouraged by his clinical team. However what was not explored was the extent to which this may have been an attempt to deal with the residual symptoms which he was experiencing or was simply recreational use of the drug.

The panel noted that Patient C was only seen twice by Consultant 2 during the period 2003 to 2005 - in May 2003 and October 2003. As someone diagnosed with paranoid schizophrenia who was being prescribed antipsychotics and subject to enhanced CPA the panel would have expected him to have been seen more frequently or a more assertive approach taken to attempt to see him.

Commentary on his admission in 2005

In the January 2005 admission, there is a marked discrepancy between the presentation given in the MHA assessment of ASW2, which is indicative of a psychotic relapse, and the view of the in-patient team and Consultant 3 that Patient C was merely intoxicated with alcohol. The final outcome was that he was discharged without follow-up. It is not clear to the panel how much this decision had been influenced by the emerging view that Patient C's problems were more of a social than of a psychiatric nature. The panel does find it surprising that no follow-up

was deemed necessary given his diagnosis of paranoid schizophrenia, non-compliance with medication and the history of symptoms given by his mother leading up to this admission. This was despite there being some indication that he was willing to engage with services as evidenced by the fact that he remained in hospital in 2005 as a voluntary patient, his mother had reported in November 2004 that he was willing to take medication and he had told his GP that he was willing to see ASW1.

Commentary on need for assertive outreach

The possibility of involving assertive outreach was mentioned at various points during this period due to poor medication concordance, missed appointments, poor life skills, potential of Patient C moving away from family support, and his various psychosocial stresses. In oral evidence Consultant 2 described Patient C's engagement as 'superficial', being 'reserved' and 'reticent to being open'.

There does not appear to have been any forum in which a referral to assertive outreach was formally discussed. Whether it would have made a difference is a moot point. The failure to refer may have been related to the subtle but clear shift of emphasis in the formulation of Patient C's problems from being illness-driven to being socially-driven, a view perhaps reinforced through the absence of apparent relapse despite various stressors.

Commentary on criminal activity

No evidence presented to the panel suggested that Patient C's involvement with the criminal justice system at this time was directly driven by his mental illness or his use of illicit drugs.

Period from 2005 of increased criminal justice involvement, relapse and eventual hospital admission in 2006

At the beginning of this period there was no actual mental health involvement, although Patient C was not formally discharged until April 2005. There was then an increasing number of criminal justice contacts, including prison detention. The period culminated in a relapse in his schizophrenia and admission into hospital.

During this period, Patient C had multiple contacts with the criminal justice system for a variety of offences, including road traffic offences (May 2005), theft (August 2005), assaulting his mother and sister (August 2005), and an offence of battery (September 2005). He received a number of different disposals including two community orders. He was also seen for a number of breaches of his bail and supervision conditions.

On 24 November 2005 his mother took him to see his GP with a history of him assaulting her and his sisters and behaving strangely, but this was denied by Patient C and in the absence of any positive symptoms being seen at the surgery, the plan was for him to be followed up by the practice CPN, CPN3. He failed to attend an appointment with him. He also failed to attend a further GP appointment in December 2005.

On 14 April 2006 he assaulted his sister, for which he was arrested on 25 April, and remanded to prison on 26 April. On 8 May 2006 he was sentenced to 4 months imprisonment for the offence.

This was not the first time he had been in custody. However it is noteworthy that during 2005 and 2006, when he was received into prison on a number of occasions, increasingly concerning behaviours were noted. On 14 May 2005, he had been reviewed by the prison mental health in-reach team at the request of his mother, but he seemed to settle and no active interventions were required. During his second period of remand, in September 2005, his mother again contacted the prison services. After initial denials, he later admitted auditory hallucinations and receiving messages from the television and radio. During his prison remand in February 2006 Patient C was again behaving strangely and expressing odd thoughts. A need for a psychiatric review and medication was identified by the in-reach team, but this did not occur.

Whilst in prison on 20 March 2006, he reported that his mother was not his real mother and that his real mother had been fatally stabbed and shot. His probation officer requested an appointment with Consultant 3 for the preparation of a court report. This was arranged for 30 March 2006 by which time he had been released, but he did not attend.

Following his remand into custody on 26 April 2006 significant concerns regarding his mental state were again noted by the in-reach team. This included at various points from 5 May 2006 to 7 July 2006: delusional beliefs that his mother, father and sister were not his real relatives; flight of ideas; pressure of speech; bizarre conversations; believing people could read his mind; inappropriate laughter; thought disturbance; mood incongruity; appearing guarded and distracted; expressing the idea that the mirror showed that his face has changed shape and he had grown fangs and experiencing an inner voice - with both commands and commentary being heard.

Concerns were such that preparations were made for him to be transferred to hospital under Section 47 MHA, but in the end this did not occur even though the medical recommendations were made. Instead he was admitted informally to St George's Park Hospital Northumberland on the day he was released from prison on 7 July 2006.

Patient C was first admitted to Newton Ward, St George's Park Hospital, which is the admissions ward, where he remained for just over three weeks. Whilst there he submitted urine for drug screening, including the day after admission, which tested negative. A similar clinical picture to that observed in prison was seen on Newton Ward. He continued to believe that his mother and sister were not his real relations, he laughed and giggled inappropriately, he described and was observed to have accelerated speech and movements, and there was some sexual disinhibition and paranoia. At times he appeared tense and angry, but mostly he was pleasant. There was an indirect threat made against a male patient ("Things need to be sorted in here or people will get their faces smashed in") but there was no direct threat and no actual interpersonal violence occurred. There were also some bizarre behaviours, including wandering around the ward with toothpaste on his face, stating it would help heal his scars.

The impression of the clinical team on Newton Ward was that he was experiencing a psychotic relapse. He had been commenced on Olanzapine at his admission, initially at 10 mg daily, but this was increased after two weeks to 15 mgs when there had not been an adequate response.

Patient C was transferred to Embleton Ward on 31 July 2006 for rehabilitation. The transfer would have occurred earlier but was delayed because of a lack of bed availability. Although there are occasional entries suggestive of ongoing psychosis, they are less frequent than when he was on Newton Ward. Clinical records indicate that doubt was expressed by some staff as to his need for rehabilitation.

The medical team, following concerns expressed by the family regarding him being discharged on oral medication, engaged him in discussion around the re-introduction of depot antipsychotic. He initially agreed to this, but later withdrew his consent.

Consultant 3, who had up until this point been on leave, saw him for the first time on 15 August 2006. During this interview Patient C denied any active symptoms, and indeed said that he had made up previous symptoms "in order to get people off my back." Consultant 3 found there was no evidence of mental illness at interview.

On 17 August SHO2 reviewed documentation that had been obtained from the prison. He noted Patient C's violent outbursts, bizarre thoughts about his family, thought disorder and flight of ideas, but a lack of auditory hallucinations. He also reviewed his presentation on Newton Ward, and concluded that 'There has been no clear evidence of psychotic features' noting instead 'behavioural problems' and a potential risk to others.

Patient C was discharged on 17 August 2006 following an urgent review by Consultant 3 prompted by an incident earlier that day when Patient C destroyed property on the unit resulting from his misinterpreting staff laughing at him. He was arrested and taken from the ward by the police, to be held overnight and to appear at South East Northumberland Magistrates Court on 18 August 2006.

Commentary regarding prison

The periods of time that Patient C was in prison are associated with the reporting of signs and symptoms, which ultimately amounted to a clear description of a relapse in his paranoid schizophrenia. This reporting may be due to prison being a particularly potent stressor for Patient C and/or due to the greater opportunity for observation.

There was a failure adequately to address Patient C's psychiatric needs during the time he served for assaulting his sister in 2006. There was an opportunity for him to have been prescribed antipsychotic medication whilst he was in prison, but he was not restarted on medication until his admission to hospital on 7 July 2006. Adequate treatment at an earlier time may have negated the need for him to be admitted to hospital.

Commentary on his admission to hospital in 2006

It is the unambiguous view of the panel that when Patient C was admitted to hospital in July 2006 he was experiencing a relapse in his paranoid schizophrenia. The discharge letter did not give an accurate reflection of Patient C's diagnosis or the course of this particular episode of his illness. His psychotic presentation both in prison and in hospital was not adequately described in the discharge letter. The discharge letter's differential diagnosis gives the impression that Patient C's problems were primarily due to his personality and illicit substance misuse, and that his schizophrenia was not an active problem.

The prominence given to Patient C's presentation being due to his personality is not backed up with sufficient evidence to justify this emphasis. There was no formal assessment of his personality during his admission. There is no evidence that the team gathered the information required to make a general diagnosis of personality disorder. There was no systematic approach to whether he met any of the criteria of the personality disorder subtypes (such as paranoid personality disorder). The discharge summary gave as a differential diagnosis 'Paranoid personality trait', which is not in itself a diagnosis.

The differential diagnosis of 'Mental and behavioural problems due to substance misuse' is not justified given the admission did not find any evidence of substance misuse, either from the immediate presenting history or on drug testing.

Maintenance in the community up until the index offence

The period leading up to the killing of Victim C was settled from the perspective of the CMHT, though there was some collateral information unknown to the CMHT that

Patient C's judgment was impaired, he was drinking heavily and was non-compliant with medication.

Upon his arrest and removal from Embleton Ward on 17 August 2006, Patient C appeared the following day before the Magistrates Court and was given a conditional discharge. His community care was picked up by ASW1 and he was continued on Olanzapine 15 mg. An early priority was to establish a more permanent residence, as he was moving between various members of the family. Eventually BBHA accommodation was secured for him and after a period of time on the waiting list he moved there on 15 January 2007.

Patient C was regularly seen by ASW1, whose notes reflect a regular review of mental state and risks. No significant deterioration in mental state or escalation of risk was detected by ASW1 from the time of Patient C's discharge from hospital to his committing the index offence. There was a brief episode of minor paranoia, reported during a home visit on 19 October 2006, attributed to his having missed his medication for three days as he had forgotten to pick up a new prescription for Olanzapine. This explanation was accepted, and Patient C reported that this provided him proof as to the necessity of his medication. Patient C appeared to have insight and engaged, if only briefly, with ASW1's attempt to explore the possibility of using a CBT model with him.

From the point of his discharge from hospital on August 17 2006 until the incident that lead to the death of Victim C on 15 August 2007, Patient C was seen only once by a consultant psychiatrist, on 25 October 2006, but this encounter was not recorded and there was no correspondence with the GP. There was no direct psychiatric review of his mental state or medication from 25 October 2006 to 15 August 2007.

He was seen by GP1 during this period, who recorded on a DVLA form dated 7 June 2007 his concerns regarding Patient C's lack of insight and poor judgment, excessive alcohol misuse and non-compliance with medication since April. The GP records at the time were registering his diagnosis as paranoid personality disorder, with no reference to him having paranoid schizophrenia. This directly relates to the discharge summary dated 18 August 2006. The last correspondence from a

consultant to his general practice explicitly giving his diagnosis as paranoid schizophrenia is Consultant 2's letter of 26 September 2003.

Commentary regarding Patient C's diagnosis at the time of the killing

It is the view of the panel that Patient C's diagnosis of paranoid schizophrenia, obtained during his hospital admission when aged 16, was correct at that time and remained correct at the time of the killing of Victim C.

There were periods throughout his life when Patient C's symptoms were in remission, and on the whole his mental health appeared quite robust in the face of a number of social stresses that he experienced during late adolescence and early adulthood. This included periods where he was non-compliant with medication and abusing alcohol and illicit substances. The fact that someone can be medication-free, misusing substances, and experience a significant number of stressors but not suffer a relapse in their schizophrenia does not refute the original diagnosis. Stressors triggering relapse are unique to the individual, as is the response to stopping medication.

Commentary regarding concordance with medication

It is unclear as to the extent Patient C was non-concordant with his Olanzapine during this period. Two very different pictures were obtained from the evidence of GP1 and his care co-ordinator.

Given his past history of non-compliance with prescribed medication and hiding this fact from professionals, any suggestion of non-concordance should have been rigorously examined. The lack of communication between GP1 and the CMHT regarding medication non-compliance meant that the team did not monitor more closely his mental state or prompt them to hold a formal psychiatric review. Conversely the lack of any correspondence between the consultant and the GP during this period is likely to have resulted in the GP notes not being corrected as to his diagnosis (which remained paranoid personality disorder).

Commentary regarding his mental state at the time of the killing

There was no evidence brought to the attention of the panel of overt or florid symptoms at the time of the killing. However the panel concurred with the opinion of three of the four psychiatrists who produced reports for the court that at the time of the killing he is likely to have had residual symptoms that may have contributed to the circumstances leading to his committing the act.

Commentary regarding the possible influence of substance misuse

It is difficult to be absolutely certain of Patient C's degree of substance misuse, as there are markedly different accounts given by him in the records at different times and to different people. There does appear to be a view formed by some involved in his care that many of his problems were secondary to his social circumstances and substance misuse. The consequence of this may have been to distract attention away from a more robust management of his paranoid schizophrenia.

The extent to which in particular he was abusing alcohol at the time leading up to the killing of Victim C is unclear.

Commentary on Patient C's offending history and its link to his diagnosis

Patient C had five convictions for violent offences prior to the killing of Victim C on 15 July 2007. The first conviction was when aged nineteen, of assault occasioning actual bodily harm, to a seventeen-year-old male when Patient C punched him to the ground and kicked and punched him further. The second offence was when aged twenty of using threatening behaviour with intent to cause fear of violence. Aged twenty one, he was convicted of battery and common assault after he punched his mother and threatened to kill her and other members of the family. Later in the same year he was convicted of battery of a female unknown to him when, without provocation, he punched the victim about the head and arms.

There was no evidence presented to the panel which demonstrated that any of the episodes of interpersonal violence were a direct consequence of Patient C experiencing hallucinations, being delusional or as a result of other psychotic phenomena. Nonetheless, the significant history of violence should have formed part of Patient C's risk assessment and have been addressed through his care plan under the CPA.

Policy and Practice Issues

First Admission 26 January 2001

Patient C was admitted to the YPU via a GP referral on 26 January 2001. He was detained under Section 5(2) MHA and subsequently Section 2 then 3.

The panel did not have access to the local CPA policy for the above dates. However the documentation used by the services indicates that care management and the care programme approach were used in a combined process and included a risk assessment component. This was confirmed by staff who were interviewed by the panel.

The requirements of the CPA for people referred to specialist psychiatric services were first laid out in circular HC (90) 23: 'Caring for People'. HC (90) 23 was supplemented, in 1999, by a policy booklet published by the Department of Health entitled Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach. The four main elements of the CPA are:

- 'Systematic arrangements for assessing the health and social needs of people accepted into specialist mental health services;
- The formation of a care plan which identifies the health and social care required from a variety of providers;
- The appointment of a key worker to keep in close touch with the service user and to monitor and coordinate care; and
- Regular review and, where necessary, agreed changes to the care plan.'

The policy identifies two levels of care co-ordination; 'Standard' and 'Enhanced' and states:

'The characteristics of people on standard CPA will include some of the following:

- they require the support or intervention of one agency or discipline or they require only low key support from more than one agency or discipline;

- they are more able to self-manage their mental health problems;
- they have an active informal support network;
- they pose little danger to themselves or others;
- they are more likely to maintain appropriate contact with services.

People on enhanced CPA are likely to have some of the following characteristics:

- they have multiple care needs, including housing, employment etc, requiring inter-agency co-ordination;
- they are only willing to co-operate with one professional or agency but they have multiple care needs;
- they may be in contact with a number of agencies (including the Criminal Justice System);
- they are likely to require more frequent and intensive interventions, perhaps with medication management;
- they are more likely to have mental health problems co-existing with other problems such as substance misuse;
- they are more likely to be at risk of harming themselves or others;
- they are more likely to disengage with services.'

The policy stipulates that service users are to be given full information about the CPA process and a copy of the agreed care plan.

Section 117 of the 1983 MHA requires health and local authorities to provide after-care for patients who have been detained under certain sections of the MHA. This is a statutory duty.

Commentary

The earliest care co-ordination policy the panel had access to was the Newcastle, North Tyneside and Northumberland Mental Health NHS Trust (3Ns) policy dated March 2003.

The documentation used in the care of Patient C was headed 'Northumberland Care Management Form'. Sections within the documentation, that is the care plan cover sheet (CM 6) and the care plan itself, made reference to CPA levels. Patient C was registered as needing enhanced CPA as well as subject to Section 117 follow-up arrangements.

The documentation indicates the CMHT was using both CPA and Care Management systems in tandem at this time. The panel was informed by one of the staff interviewed that social workers within the team did have a dual role both as care managers and as care co-ordinators within CPA.

Consultant 1 referred Patient C to the adult CMHT (services for working age adults covered the 16 to 64 age range). The referral was processed and allocated appropriately within the CMHT. CPN1 undertook a full assessment, including risk factors, and drew up a care plan based on Patient C's needs. The care management documentation records Patient C as having a diagnosis of schizophrenia and 'in relapse a high risk of violence'.

The panel was informed that the CMHT did not have an operational policy, nor are there records in regard to how cases were allocated and reviewed.

The panel is of the view that the care of Patient C during this period was in accordance with national guidance.

Transfer of care co-ordinator duties

In November 2001 care co-ordinator responsibility transferred from CPN1 to ASW1. A letter was sent to Patient C by CPN1 notifying him of the change and informing him that ASW1 would be contacting him to arrange an appointment in due course.

On the 22 November 2001 Patient C was seen at his aunt's home by CPN1 and ASW1. Thereafter, as the new care co-ordinator was a social worker, arrangements were made for CPN 2 from the same CMHT to administer Patient C's depot injections.

Commentary

The transfer of care co-ordinator duties was satisfactory. Patient C was informed of the proposed change and a joint visit took place to introduce him to his new care co-ordinator.

Ongoing community care following second discharge in July 2002

Throughout the remainder of 2002 and into 2003, ASW1 maintained regular contact with Patient C and his family. A formal review was held on 3 April 2003 with Consultant 1. The review noted that Patient C remained on enhanced CPA; however, his requirement for Section 117 after-care was not noted.

Commentary

The regular contact with Patient C and his family following his discharge from inpatient care in July 2002 up to the period when it was proposed that he transfer from young people's services to adult mental health services was satisfactory and in accordance with good practice.

ASW1 provided updates to Consultant 1 and Patient C's GP on his involvement.

At the review on 6 March 2003 the fact that Patient C was subject to Section 117 after-care was no longer noted within the care plan. From then on there was no review of Section 117 after-care arrangements up to the time of the incident in July 2007. The fact that Patient C was subject to Section 117 after-care appears to have been lost sight of at this time and to have disappeared from the consciousness of the CMHT. The result of this was that there was never a formal review of Patient C's Section 117 status and no discharge from it. Had the documentation accurately recorded the fact that he was subject to S117 after-care, that would automatically have notified in-patient medical teams of the fact that he had previously been subject to compulsory treatment under the MHA.

CPA review 16 January 2004

ASW1 conducted a CPA review with Patient C on 16 January 2004 in which he noted that Patient C was not taking his medication and was refusing his depot medication. ASW1 wrote to Consultant 2 with an update following the review and informing her of Patient C's decision to stop medication.

Consultant 2 responded to ASW1 suggesting there should be a full review with Patient C to consider his decision to stop medication and whether contingency plans needed to be put in place.

A review was organised for the 25 March 2004 however Patient C refused to attend.

Commentary

Patient C refused his depot medication in December 2003; his last dose had been administered on 6 November 2003. This was brought to the attention of Consultant 2 by letter of 14 January 2004 and a review was suggested by her on 16 January 2004. A review was scheduled for 25 March 2004. It is not clear to the panel why there was a delay of more than two months, or, when Patient C refused to attend, why no arrangements were made for a full review of his case to take place in his absence. The proposed contingency plans were not put in place.

Ongoing community care following transfer between Consultant 2 and Consultant 3

On the 13 May 2004 a planned CPA review was scheduled to take place with Consultant 3 however Patient C refused to attend.

There was no contact with Patient C during May and June despite attempts being made to visit him and letters being written to him by ASW1.

On 11 August 2004 ASW1 wrote to Patient C advising him that if there was no contact within a month he would be discharged from the caseload and his file closed.

Commentary

There is no record of a care co-ordination MDT meeting to discuss Patient C's disengagement from services or of the decision to inform him that he would be discharged. Although ASW1 informed Patient C that he would be discharged after one month if there was no contact, there is no record within the CPA documentation that such a discharge took place. This divergence between the expressed intention to discharge and the lack of any such action reflects a lack of robust case management and supervision. At this stage there was no comprehensive ongoing care plan. The panel is of the view that, in the light of Patient C's status as being on enhanced level of CPA and his clinical history, there ought to have been more in the way of MDT meetings and risk assessment.

Discharge from CPA and the CMHT

On the 26 January 2005 Patient C was admitted to St George's Hospital for a 24 hour period.

On 20 April 2005 ASW1 wrote to GP1 stating that Patient C was now discharged from his caseload following a lengthy period of non-contact and with the agreement of Consultant3 following a discharge meeting in November 2004.

On the 25 April 2005 Northumberland care management form CM 11 was completed stating Patient C had withdrawn from services.

Commentary

This period reflected the continued lack of clear decision-making in relation to Patient C and confusion about his status on CPA. At his admission in January 2005 he had not formally been discharged from CPA but, despite this, there was no review meeting after that admission to consider the appropriate course and the management of his case continued to drift. The decision to discharge him having been taken in November 2004, this was not formally completed until April 2005 and no regard was had as to the events of January 2005.

The letter from ASW1 to GP1 in April 2005 informing him of the discharge of Patient C was sent six months after the discharge meeting that apparently took place in November 2004 between Consultant 3 and ASW1.

Fourth admission to St George's Park Hospital

Due to deterioration in Patient C's mental health he was transferred via the crisis assessment and intervention service (CAIS) from HMP Durham to St George's Park Hospital on 7 July 2006, the day of his release from prison.

A service user details and care co-ordination registration form CC 1 was completed on 7 July 2006 by a member of staff on Newton Ward at St George's Hospital. Patient C was recorded as being on enhanced CPA.

Following treatment on Newton Ward Patient C was transferred to Embleton Ward on the 31 July 2006. On 17 August 2006 Patient C was discharged from Embleton Ward and arrested for criminal damage on the Ward.

A discharge letter was sent to GP 1 by Consultant 3 and SHO 2 summarising the admission, treatment and after-care plan.

Commentary

The care co-ordination policy (policy reference number 3 NTW (C) 06 (Issue 3)) states that all discharges of people on CPA should be subject to a pre-discharge meeting or a final patient review by the multidisciplinary team including the care co-ordinator. Although Patient C was discharged because of his behaviour, there should still have been a meeting following his removal to be clear on follow-up arrangements and plans. The discharge summary does not indicate that Patient C was on enhanced CPA, although Consultant 3 in his evidence to the panel accepted that that was the case. The panel is of the opinion that the discharge process failed to accord with the CPA policy.

The discharge summary did not clearly indicate what was expected of the CMHT in regard to follow up other than to liaise with the police in regard to Patient C's behaviour on the Ward.

Ongoing community care following discharge

The initial response by ASW1 on 18 August 2006 following Patient C's discharge was to support Patient C in dealing with the criminal damage charge which resulted

in a three month conditional discharge being imposed that day, arranging for a medication prescription and support in finding accommodation.

On 19 October 2006 care co-ordination care plan CC5 was completed by ASW1 with Patient C and his mother. The plan notes that Patient C was on enhanced care co-ordination and records contingency and risk management plans. However a service user details and care co-ordination registration form CC1 was not completed until 25 October 2006 and is noted as a re-register.

Consultant 2 reviewed Patient C on 25 October 2006 with ASW1.

Commentary

The initial response by the CMHT and ASW1 was prompt and appropriate in managing the immediate issues around medication and accommodation for Patient C.

Although Patient C was registered on enhanced CPA on 7 July 2006 through the ‘service user details and care co-ordination registration form’ (CC 1), ASW1 completed another CC1 form on 25 October 2006 which was an unnecessary duplication and indicative of the confusion in relation to his CPA status at the time of his discharge from hospital.

A formal CPA care plan was drawn up on 19 October 2006 by ASW1 involving Patient C and his mother. The plan noted risk management issues and contingency plans and recorded Patient C as on enhanced CPA. The first involvement by Consultant 2 was on 25 October 2006. There is no record of this meeting nor is there a letter to GP1 on the outcome of this review.

Ongoing community care October 2006 to July 2007

ASW1 saw Patient C frequently between October 2006 and July 2007 and during those visits recorded his mental state and any risk behaviours.

On 30 April 2007 ASW1 completed a care co-ordination care plan review CC6 which includes an updated risk assessment. Patient C, ASW1 and the residential support worker were present at the review.

Commentary

ASW1, as care co-ordinator, maintained regular contact with Patient C and noted his mental state and risk issues throughout the period of contact up to July 2007.

The care co-ordination policy (policy reference number 3 NTW (C) 06 (Issue 3)) requires the care co-ordinator to communicate effectively with all those involved with service users' care. The CPA review on 30 April 2007 did not involve Consultant 2 nor was she or GP1 copied in to the review documentation or written to with the update of Patient C's care.

This failure properly to follow a CPA approach resulted in a move from a multi-disciplinary approach to managing his mental health to a uni-disciplinary social care management model.

Conclusions

Patient C has a diagnosis of paranoid schizophrenia but the death of Victim C could not in any way be said to relate directly to that mental illness. Patient C's conviction for manslaughter was not on the basis of diminished responsibility. It is clear from the evidence of the police statements and the conduct of the criminal prosecution of Patient C that Victim C was at times a violent and threatening individual who had been involved in incidents with a number of residents at the BBHA accommodation. The final incident began with Victim C coming to the room of Patient C armed with a snooker ball in a sock which led to Patient C arming himself with a knife. There then followed the altercation in which the fatal stabbing occurred. Those facts led to Patient C pleading guilty to manslaughter by reason of provocation.

The panel is of the opinion that the evidence indicates Patient C, whilst not having suffered a relapse of his illness, was not in complete remission during the period leading up to the incident. Residual symptoms included low level paranoia, poor judgement and emotional regulation and only partial insight. Those symptoms may have contributed to the way that Patient C reacted to the behaviour of Victim C and how the incident developed. Had Patient C's diagnosis of paranoid schizophrenia, embedded in a clear formulation of the case, remained to the forefront of the consideration of the MDT then there might well have been a different focus to his care and treatment. It is impossible to know whether that would have affected what happened on 15 July 2007.

Over the entire period during which Patient C was involved with the secondary mental health services the quality of his care and treatment varied. During his first period of in-patient and community treatment it was of the standard that could properly have been expected. Later aspects of it fell below the standard that patients, their families and the wider public are entitled to expect. The loss of focus on Patient C's paranoid schizophrenia may have had an effect upon the assessment of risk in that, even when not actively psychotic, the residual symptoms were something that ought to have been factored into the overall situation.

Throughout the periods of Patient C's care when he was subject to the CPA he was assessed as being at enhanced level, which properly reflected the complexity of his case. Initially the CPA process was followed rigorously with thorough risk assessments, care plans and MDT reviews. Over time the application of CPA processes became insufficiently robust with reviews missed or inadequate, a paucity of psychiatric input and an approach that had, in reality, become uni-disciplinary.

The standard of record keeping was variable; with much of it of the quality to be expected and some being excellent, but there were failings. Deficiencies include the failure to record MDT discussions and some outpatient appointments. At times there was a lack of communication between professionals and inaccurate or incomplete information about Patient C's diagnosis, risk and care was conveyed.

Had all statutory obligations and Department of Health guidance been followed, not only would the CPA requirements have been fulfilled, but the fact that Patient C was subject to S117 care from the time of his initial discharge in 2001 would not have been overlooked. This may have resulted in a more rigorous approach by the care teams with which Patient C came into contact.

A MAPPA referral was made and considered and the decision correctly taken that Patient C did not meet the criteria for inclusion within the scheme, all in accordance with policy.

Recommendations

Having examined the circumstances surrounding the health care and treatment of Patient C as set out in this report, the panel recommends that the SHA takes steps to require NTW to ensure that:

A formulation based approach to clinical management of patients is adopted. Formulation should be informed by multi-disciplinary evaluations and be regularly reviewed.

There is consultant psychiatric input in cases in which there is diagnostic complexity or uncertainty, medication related issues or significant risk.

Decisions regarding patient care are not taken on the basis of single presentations without regard to the case formulation.

In cases where issues of non-compliance with medication arise this ought to be noted specifically as part of the risk management plan. This plan should specify to all concerned how future instances of non-compliance are to be notified, as well as interventions required to develop concordance.

At each point of transition in the care of a patient there must be a concise summary readily available to the receiving service that accurately sets out the patient's formulation; which includes diagnosis, treatment plan, risk factors and follow up requirements.

All members of integrated teams have access to all of the relevant clinical information.

Appropriate weight is given to all reported concerns of carers and other key figures in patients' lives; particularly when past reporting has proved to be reliable. Whilst such policy guidance may form part of training, it is essential to achieve a demonstrable change in the approach taken by professionals in such instances.

Professionals who counter-sign any clinical document are aware that they are accountable for it and have taken steps to check its accuracy.

When professionals have dual roles, the responsibilities and functions of each is clearly set out and fully discharged.

Guidance on the management of patients whose cases are complicated by misuse of drugs or alcohol is followed. Any such misuse should be noted as a risk factor and marked in any care plan as an issue for on-going care.

An effective system is implemented to ensure that all records, including patient administration records, are appropriately made and maintained in accordance with policy and statutory requirements.

There is full compliance with policies dealing with non-attendance and, in particular, that any referrer is consulted in order to re-assess the situation and formulate an appropriate action plan.

A system of quality assurance is put in place to ensure the accuracy of diagnoses and discharge summaries.

An assurance system is put in place to ensure CPA policy is complied with and any shortcomings in individual cases are identified at the earliest opportunity in order for remedial action to be taken.

An effective system is implemented to ensure adherence to professional standards of contemporaneous clinical record keeping. This must include all discussions and events relevant to the patient's care.

There is an operational policy for each team that is kept updated and observed.

Clinical records include a flagging system in relation to S117 status.

Secondary mental health services establish with primary care services the circumstances and procedures by which changes in risk are effectively communicated to each other.

The panel also recommends to the SHA that it liaises with the North East Offender Health Commissioning Unit regarding the establishment of a system that ensures that if a prisoner requires examination by a psychiatrist and it has not occurred by the due date, prompt remedial action is taken.

Glossary

AOT	Assertive Outreach Team – specialist team working with more severely mentally ill people in the community.
ASW	Approved Social Worker – approved under the MHA.
CAIS	Crisis Assessment & Intervention Service – specialist team working with mentally ill people experiencing a crisis.
Care Management	The system used by local authorities to allocate resources to the care of adults needing support in the community.
CBT	Cognitive Behavioural Therapy – a technique to help patients understand and alter their behaviour.
CMHT	Community Mental Health Team.
CPA	Care Programme Approach – introduced in England in 1991, requires specified arrangements to be put in place for the care and treatment of mentally ill people in the community.
CPN	Community Psychiatric Nurse.
Depot Medication	Long acting medication given by injection.
EEG	Electroencephalography – records brain activity.
MAPPA	Multi Agency Public Protection Arrangements - Policy requiring Police, Probation Service and any other relevant agencies to work together over concerns for public safety.
MHA	Mental Health Act 1983.
Section 2	Provides authority for someone to be detained in hospital for assessment.
Section 3	Provides authority for someone to be detained in hospital for treatment.
Section 5(2)	Provides authority for someone to be detained in hospital for up to 72 hours.

Section 47	Provides for transfer of serving prisoners to hospital.
Section 117	Imposes a duty on statutory authorities to make arrangements to provide after care and support to persons who have been treated under the MHA.
SHO	Senior House Officer – Doctor in post graduate training.
YPU	Young People's Unit – a specialist unit providing psychiatric assessment and care for children and young people.

Bibliography

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- 2 3Ns Trust medical records for Patient C
- 3 3Ns Trust multi-disciplinary records for Patient C
- 4 Primary health care/GP records for Patient C
- 5 HM Prison Service healthcare records for Patient C
- 6 NTW Trust’s policy responses to national guidance from the Department of Health and others including:
 - Care Co-ordination Policies
 - Non Attendance Policy
 - Risk Management Policy
 - Crisis Assessment and Intervention Service Policy
 - MAPPA Policies
 - CMHT Operational Policy
- 7 Department of Health Policy Guidance including:
 - HC(90)23/LASSL(90)11 – “Caring For People”: The Care Programme Approach for people with a mental illness referred to the specialist psychiatric services - 1990.
 - Effective Care Co-ordination in Mental Health Services: Modernising the Care programme Approach - October 1999
- 8 Police report of their criminal investigation
- 9 Northumbria Probation Trust records and MAPPA Policy
- 10 Reports of Consultant Psychiatrists prepared for court proceedings involving Patient C