MR A

Report

October 2013

ACKNOWLEDGEMENT

This is a report of the Independent Investigation into the care of Mr A by Community Mental Health Teams operated by Hertfordshire Partnership NHS Foundation Trust ('HPFT') in the period leading up to the death of the Deceased on 14 June 2007. The Independent Investigation Team would like to extend its condolences to the Deceased's family and all those touched by his death.

This report focuses upon the potential learning for the Community Mental Health Teams operated by HPFT in order to try to help reduce the risk of such a tragedy happening in the future.

The Independent Investigation Team recognises that a great deal of work has already been undertaken to improve services within the Community Mental Health Teams. The Independent Investigation Team hopes that this report will give those involved in the delivery of mental health services within HPFT a further opportunity to reflect upon how it can maximise the quality of the care which it delivers.

In undertaking this Investigation, HPFT has co-operated substantially with the Independent Investigation Team. The Independent Investigation Team is grateful for this assistance.

TABLE OF CONTENTS

1.0 EXECUTIVE SUMMARY

1.1 Mr A's history demonstrated considerable and long-standing contact with mental health services from a relatively early age. The psychiatrists who assessed Mr A were of the view that Mr A's problems included personality difficulties, drug and alcohol abuse and risk to self and others. His specific diagnosis changed over time but antisocial and borderline personality traits were repeatedly identified.

1.2 Mr A's care co-ordinator was Consultant Psychiatrist 1, working with Dacorum CMHT, through which Mr A's care was delivered. Mr A's past medical history reveals a pattern of non-attendance at appointments with mental health services. In both 2002 and 2004, Mr A was discharged from care by CMHTs as a result of non-attendance.

1.3 In February 2006, Consultant Psychiatrist 1 took the decision that he would remain responsible for Mr A's care due to difficulties which Mr A had in trusting people. Consultant Psychiatrist 1 was of the view that he and Mr A 'went back a long time' and had an established relationship.

1.4 Mr A was living in Harpenden, outside the catchment area of Dacorum CMHT, throughout a significant part of his care. During November 2006 Consultant Psychiatrist 1 arranged for Mr A to be seen at the Cassel Hospital with a view to ascertaining his suitability for residential treatment. The Cassel Hospital provided national specialist assessment and treatment services for adults and families encountering intractable personality and family problems.

1.5 The Cassel Hospital confirmed that Mr A could benefit from inpatient care on 7 December 2006, due to a mixed personality disorder with borderline, antisocial and narcissistic traits. A serious tendency for violence, both in Mr A's relationships with his partners and others, was highlighted, as was Mr A's extensive use of alcohol and drugs. Funding to support Mr A's referral was eventually denied.

1.6 On 8 January 2007 an emergency MAPPA meeting was convened to discuss threats made by Mr A to a member of a social services team who was responsible for supervising Mr A's contact with his daughter. As a result Mr A was registered at MAPPA Level 3. This level of risk was later 'downgraded'.

1.7 Appointments for Mr A to see Consultant Psychiatrist 1 were sent to Mr A on 16 January 2007 and 16 March 2007. Mr A failed to attend these appointments. In addition, Mr A failed to attend a further appointment on 13 March 2007 with

Consultant Psychologist 1, with whom he was undergoing a short course of CBT. As a result, Consultant Psychiatrist 1 wrote to Mr A's GP on 27 March 2007 discharging him from his care.

1.8 However, notwithstanding the fact that he had discharged Mr A, Consultant Psychiatrist 1 then referred Mr A to the Henderson Hospital, which offers similar services to those of the Cassel hospital, on 22 May 2007, at the request of Mr A's solicitors.

1.9 On 6 June 2007, Consultant Psychiatrist 1 wrote to Consultant Psychiatrist 2 at St Albans CMHT purportedly transferring Mr A's care to St Albans CMHT. However, as a result of a failure to undertake an appropriate CPA handover, transfer was not completed.

1.10 Mr A was found guilty of the murder of the Deceased. Mr A stabbed the Deceased during a fight on 13 June 2007. The Deceased died the following day from his injuries.

Was Deceased's death Preventable or Predictable

1.11 The Independent Investigation Team's view is that it was predictable that Mr A could behave violently and had done so historically. This was well known to the CMHT. Mr A's violent behaviour has been documented as part of this investigation.

1.12 None of the failures identified in this report should have happened. However, even if Mr A had been fully assessed, and psychiatric or psychological interventions implemented, it does not follow that the risk of violent behaviour would have been reduced. Not only is there uncertainty about the likely effectiveness of such interventions in his case but the outcome for any one individual can be influenced by a range of factors which are outside the control of professionals such as those in the Dacorum CMHT.

1.13 Simply establishing that there were actions that could have been taken would not provide evidence of preventability, as there are always areas of care provision that could be carried out more effectively.

Availability of Services

1.14 In 2007, HPFT did not have a dedicated multidisciplinary Personality Disorder Service. This meant that the complex and challenging needs of an individual such as

Mr A gave no alternative but to obtain care from a variety of sources with the attendant risk that his needs could fall between the gaps in service provision.

1.15 Consultant Psychiatrist 1 at Dacorum CMHT maintained contact with Mr A and attempted to co-ordinate his needs through the CMHT. Consultant Psychiatrist 1 was able to establish a relationship of trust with Mr A and signposted Mr A to a range of community services which were available to him at that time. This is an element of good practice. Mr A did not always comply with referrals made by Consultant Psychiatrist 1 in this respect.

1.16 A dedicated personality service was established by HPFT in 2009. This is an element of best practice that was not available to Mr A in 2007. It is clear that had this service been available in 2007, Mr A could have been sign posted there in order to receive multidisciplinary care targeted toward the needs generated by the issues which he faced. It is clear that the availability of such a service reduces the risk of an individual with a combination of personality disorder and substance misuse falling through the gaps in service provision and can provide improved case management and pathways of care.

Care Programme Approach

1.17 Mr A was entered into the CPA on 27 May 2002. Mr A remained on standard CPA throughout his care. This is a matter for concern for the Independent Investigation Team as there were many factors in Mr A's presentation which would have suggested that enhanced CPA care was more appropriate for his individual presentation.

1.18 In particular, enhanced CPA would have provided Mr A with access to multidisciplinary team consideration and decision making, together with the enhanced risk management processes which were absent in Mr A's care.

1.19 Further, the Independent Investigation Team could not find any evidence of a comprehensive CPA care plan within Mr A's notes nor any evidence of any CPA reviews taking place in relation to Mr A's care in the eighteen month period prior to the Deceased's death. This is despite significant changes taking place in Mr A's circumstances during this time.

Risk and Needs Assessment

1.20 The Risk Assessment and Management Policy in place at the time of Mr A's care required care co-ordinators to gather information relating to the risk posed by service users to themselves and others as part of a risk assessment. It also required any situations likely to lead to an increased risk of harm to be identified and where possible discussed in a multidisciplinary meeting.

1.21 A risk report was produced by a Forensic Psychologist in October 2005 which included an assessment of Mr A's static violence risk and identified some dynamic risk factors. This report suggested that 55% of offenders similar to Mr A would offend violently in the future and that there was a risk of both domestic and stranger violence.

1.22 Mr A was the subject of meetings of a Multi-Agency Public Protection Panel (MAPPP) during his care by HPFT. The purpose of a MAPPP is to enable co-ordination between services to manage certain individuals deemed to pose a significant risk and to determine Multi-Agency Public Protection Arrangements (MAPPA). At times throughout his care, Mr A was registered at MAPPA Level 3, which is the highest level and indicates a complex case posing serious risks. At the time of the deceased's death Mr A was registered at Level 2.

1.23 The risk presented by Mr A was known to those responsible for delivering his care. However, Mr A's care co-ordinator did not appear to have completed formal risk assessments of Mr A. There is no single document providing a comprehensive summary of the static and dynamic risk factors which could impact upon Mr A during key stages in his presentation or when significant events occurred. This had implications for the on-going assessment and management of risk presented by Mr A and was a significant concern for the Independent Investigation Team.

Care Co-ordinator

1.24 Consultant Psychiatrist 1 was Mr A's care co-ordinator from 28 May 2004. It is important that a service user trusts their care co-ordinator. Where service users have significant patterns of non-engagement, it is important to maintain stability in their care co-ordination. Consultant Psychiatrist 1 maintained a positive relationship with Mr A. This is to be commended in light of Mr A's known engagement issues.

1.25 Mr A had a complex presentation and was involved with numerous services during his treatment by HPFT. The role of care co-ordinator was likely to require a

significant time commitment. The Independent Investigation Team are concerned that Consultant Psychiatrist 1 may not have had the capacity to carry out the necessary functions of the care co-ordinator given his other clinical commitments.

1.26 Mr A's mother and his partner were present at certain times in Mr A's presentation and played a part in his life throughout his contact with mental health services. Mr A's living arrangements were disrupted for a variety of reasons, including criminal convictions, disputes with his partner, and his own actions which resulted in him being ineligible for council accommodation. At times, he was resident in his mother's home and at other times was living with his partner.

1.27 It does not appear that Mr A's mother or partner were considered as carers of Mr A at any given stage. It is also unclear as to why their views about Mr A's presentation and difficulties were not incorporated into Mr A's care plan.

Discharge from CMHT Care on 27 March 2007

1.28 On 26 April 2007, Mr A's solicitors contacted Consultant Psychiatrist 1 to facilitate a referral to the Henderson Hospital. This was on behalf of Mr A, notwithstanding that Consultant Psychiatrist 1 had discharged Mr A. Consultant Psychiatrist 1 referred Mr A to the Henderson Hospital on 22 May 2007. The Henderson Hospital responded asking Consultant Psychiatrist 1 for CPA information and to complete referral forms.

1.29 At this point Consultant Psychiatrist 1 effectively resumed his previous role as care co-ordinator for Mr A.

1.30 Mr A's care co-ordinator did not take action to ensure that the requirements of the Care Programme Approach were reviewed at this time. In particular, he failed to carry out a risk assessment and ensure that a care programme was put in place. These are key requirements of a care co-ordinator's responsibilities.

Transfer of Care Co-ordinator

1.31 Consultant Psychiatrist 1 informed Consultant Psychiatrist 2 on 6 June 2007 that he was transferring responsibility for Mr A to her. Consultant Psychiatrist 1 also notified Mr A directly that Consultant Psychiatrist 2 would be acting as care co-ordinator and that Consultant Psychiatrist 2 was taking on responsibility for Mr A's transfer to the Henderson Hospital.

1.32 On 8 June 2007, the St Albans CMHT Manager informed Consultant Psychiatrist 1 that a formal care transfer should be carried out and that Consultant Psychiatrist 1 should continue as care co-ordinator until that took place.

1.33 Consultant Psychiatrist 1 attempted to transfer Mr A's care to Consultant Psychiatrist 2 without carrying out a CPA review, risk assessment or detailed letter of referral. These are central to the management of an individual's care and are required in order to carry out an adequate assessment of the risk of harm to service users and others.

1.34 Consultant Psychiatrist 1 also failed to ensure the passage of key information relating to Mr A's circumstances, including the involvement of the MAPPP, to Consultant Psychiatrist 2. Whilst it is clear that St Albans CMHT had some information about Mr A, it is still necessary for a full set of information to be handed over as part of a care transfer. This was a significant failing that could potentially have left individuals responsible for Mr A's care unaware of significant risk factors.

1.35 Consultant Psychiatrist 1 failed to inform other services responsible for management of Mr A of the change in care co-ordinator, including the MAPPP. This is a significant concern.

1.36 The Independent Investigation Team has reviewed the CPA and Risk Assessment Policies in force at the time of the death of the Deceased. The Independent Investigation Team has no criticism of the content of these policies. Had they been applied they would have effected a proper transfer of care.

Clinical Governance

1.37 The Independent Investigation Team could not find any evidence that Mr A's care had received any form of multidisciplinary consideration within Dacorum CMHT as required by HPFT policy. Consultant Psychiatrist 1 remained Mr A's care co-ordinator throughout his care and appears to have been acting effectively in isolation.

1.38 The Independent Investigation Team were advised that there was no mechanism for ensuring the review of patients on a regular basis by the MDT. The absence of a mechanism to ensure systematic review of patients in an MDT context risks a reduction in the quality of service delivery to service users.

1.39 In particular, the Independent Investigation Team are concerned that the results of the Internal Investigation into Mr A's care, as discussed below, were not part of an

MDT or peer review process which would have allowed Consultant Psychiatrist 1 an opportunity for reflection in the context of professional growth and development.

Internal Investigation

1.40 HPFT became aware that Mr A had been arrested in relation to a homicide on 21 June 2007.

1.41 A SUI Report was completed by the Dacorum CMHT Manager. This Report was written without interviewing key members of staff involved in Mr A's care. In addition to the SUI Report, an Addendum and an Action Plan for Adverse Events were produced. The Action Plan includes a series of Root Causes/Contributory Factors and Actions to be taken. This is an example of good practice.

1.42 However, neither the SUI Report nor the Action Plan was distributed to key staff in the Dacorum CMHT, despite reference to staff in the action points having been made. Consultant Psychiatrist 1 stated that he had not seen the SUI Report until it was presented to him during the Independent Investigation. Consultant Psychologist 1 also had not been involved in the SUI process. This is a major concern for the Independent Investigation as it potentially denies staff an important learning opportunity from the issues identified by the Internal Investigation Team, relating to Mr A's care.

2.0 RECOMMENDATIONS

CPA

1. HPFT should incorporate into its audit plan, an audit to determine whether the criteria for standard care or CPA are being correctly applied.
2. Many of the concerns highlighted by the Independent Investigation Team have been addressed in systematic changes made by HPFT. However, the Independent Investigation Team notes that a patient transferring from a local team to another local team within the same service is not the subject of a formalised procedure. The Independent Investigation Team believes that a formalised procedure should be adopted in this regard.
3. The Independent Investigation Team believes that the allocation of a psychiatrist as a co-ordinator is acceptable in exceptional circumstances. However, these circumstances should be identified in a procedure which includes an element of multidisciplinary working.

Risk Assessment

4. The Independent Investigation Team recommends that the referral criteria for risk assessment between services are reviewed to ensure that patients can be referred expeditiously in order that risk is managed effectively and expeditiously at all times.
5. The Independent Investigation Team are of the view that in the event that a Consultant Psychiatrist is a patient's designated care co-ordinator, structures should be put in place to ensure that this individual is supported in practical terms to fulfil this role and their other clinical commitments.
6. Staff must be encouraged to recognise and identify potential carers. HPFT should include in its audit programme an audit to determine whether carers are being correctly identified by practitioners.
7. HPFT should conduct an audit to ensure that patients who are discharged from care are the subject of multidisciplinary review as a result of a failure to attend appointments.

Staff Guidance

8. HPFT should provide guidance to support staff in relation to the provision of informal advice to ensure that the rationale behind its control mechanisms and policies are not circumvented in the event that informal advice is given.

Care Pathways

9. A review is conducted to ensure that the current CMHS Operational Policy includes sufficient failsafe procedures to ensure that all cases are reviewed in a multidisciplinary setting where required by internal procedures.

Learning Opportunities and Professional Development

10. The Independent Investigation Team recommends that HPFT consider reviewing the vehicles which it has for peer review in relation to senior practitioners, in order to support professional growth within an overall quality improvement framework.
11. HPFT should implement the Recommendation in its Internal Report that a protocol be agreed requiring a period of joint working in the handover process involving complex patients.

3.0 INTRODUCTION

3.1 Iodem Health Limited was commissioned by NHS Midlands and East (the 'SHA') to undertake an Independent Investigation into the care and treatment of Mr A in the period leading up to the death of the Deceased.

3.2 Mr A was found guilty of the murder of the Deceased and was sentenced to imprisonment for life. The minimum term Mr A must serve before he can be considered for parole is 16 years, less 298 days which he served in custody awaiting trial.

3.3 During the trial, the jury heard how there was a history of bad feeling between Mr A and the Deceased, who both had convictions for violence and drugs. A long standing feud between the two men ended on 13 June 2007 when Mr A stabbed the Deceased seven times in the chest and back. Earlier that evening, they had played pool together in a pub in an apparent truce. However, later, back at the Deceased's flat Mr A carried out the stabbing. The Deceased, whose spleen was severed in the attack, managed to drive himself to hospital where he underwent two emergency operations. However, following a heart attack, he died some hours later.

3.4 During the course of the trial, jurors heard how Mr A suffered a broken arm in an attack, said to have been carried out by the Deceased and two other men, in Hemel Hempstead in 2005.

3.5 Passing sentence, Judge Michael Baker QC told Mr A:

> *'In the pub there was no sign of trouble between you and the Deceased but earlier events make it likely you bore him a grudge.'*

3.6 The Independent Investigation has been conducted in accordance with HSG 94 (27), Department of Health Guidance. This refers to the circumstances in which:

> *'a homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced care programme approach, of specialist mental health services in the six months prior to the event.'*

3.7 The purpose of an Independent Investigation is not to apportion blame but to promote learning in an attempt to improve the delivery of services so as to reduce the risk of a similar event occurring in the future.

3.8 Independent Investigations conducted in accordance with HSG (94) 27 are entirely separate from the legal processes that take place following a homicide. The aim of

such investigations is not to investigate the circumstances of the death, but is instead to enable the providers of care to learn lessons and make improvements for the benefit of future service users, their carers and the public.

3.9 Consequently, the principal purpose of the Independent Investigation into the care of Mr A is to provide the SHA with clear recommendations about what action it needs to take to maximise learning from this case and ensure that it is used to improve mental health services delivered by Community Mental Health Teams operated by Hertfordshire Partnership Foundation Trust. In doing this, the Independent Investigation Team recognises that HPFT has made a number of significant changes to its practices and procedures since 2007.

4.0 INVESTIGATION TEAM

4.1 Iodem Health Limited ('Iodem') undertook the Independent Investigation.

4.2 The Independent Investigation was carried out by the following individuals who are unconnected with Hertfordshire Partnership NHS Foundation Trust (HPFT) (the 'Trust') and the East of England Strategic Health Authority (the 'SHA'):

Janet Hawthorne LLB (Hons) - Lead Investigator, Regulatory Lawyer
Dr Tracy Carlson – Clinical Psychologist

4.3 Biographies of the members of the Independent Investigation Team are attached at Appendix **A**.

5.0 TERMS OF REFERENCE

5.1 The following Terms of Reference were agreed with the SHA for the Independent Investigation. It was envisaged that the Independent Investigation was to be carried out in two stages and conducted in accordance with the National Patient Safety Agency Good Practice Guidance for Independent Investigations. The full Terms of Reference of the Independent Investigation are set out at Appendix **B**.

Stage 1

Following the review of clinical notes and other documentary evidence:

- Review the Trust's Internal Investigation (SUI 121089) and assess the adequacy of its findings, recommendations and Action Plan.
- Review the progress that the Trust has made in implementing the Action Plan.
- Agree with the SHA any areas (beyond those listed below) that require further consideration.

Stage 2

- Review the care, treatment and services provided by the NHS, the local authority and other relevant agencies from the service user's first contact with services to the time of her offence.
- Compile a comprehensive chronology of events leading up to the homicide and establish the circumstances of the incident itself.
- Review the appropriateness of the treatment, care and supervision of the mental health service user in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern.
- Review the adequacy of risk assessments and risk management, including specifically the risk of the service user harming themselves or others.
- Examine the effectiveness of the service user's care plan including the involvement of the service user and the family.
- Review the whole patient pathway with particular attention to the transfer of care points.
- Review and assess compliance with local policies, national guidance and relevant statutory obligations.
- Consider if this incident was either predictable or preventable.
- Consider any other matters arising during the course of the investigation, which are relevant to the occurrence of the incident or might prevent a recurrence.

- Provide a written report to the SHA that includes measurable and sustainable recommendations, ensuring the recommendations are relevant to the present day and take account of any changes made by the Trust following their own internal investigation.

5.2 The Independent Investigation Team has concentrated on the 12 month period leading up to the death of the Deceased in their consideration of the care afforded to Mr A.

6.0 METHODOLOGY

6.1 During the initial stages of the Independent Investigation, the Independent Investigation Team gathered a significant amount of documentary evidence relating to Mr A. The following documentary information and records concerning Mr A's care were obtained:

i. General Practitioner records;
ii. Clinical records maintained by HPFT;
iii. HPFT Policies and Procedures relevant to Mr A's care;
iv. Psychiatric reports carried out during the course of legal proceedings involving Mr A;
v. Documents from Mr A.

6.2 These documents were used to form the basis of the Independent Investigation and plan subsequent interviews with key participants in Mr A's care.

6.3 The Independent Investigation Team were able to interview the main participants in Mr A's care.

6.4 Prior to the interview, each interviewee received a letter from the Independent Investigation Team Leader explaining how the interviews were to be conducted. Each interviewee was provided with a copy of the Independent Investigation's Terms of Reference and a bundle of relevant documentation prior to the interview.

6.5 Following the interviews, the Independent Investigation Team met to discuss and review the information gathered, in order to prepare its report.

6.6 The benefit of hindsight can introduce unfairness into any investigation. Hindsight bias occurs when people who know the answer overestimate its predictability or obviousness, compared to the estimates of those who must guess the outcome without advance knowledge. The Independent Investigation Team has remained acutely aware of the danger of hindsight bias throughout the Independent Investigation and has tried to recognise its impact and correct it when possible.

6.7 In carrying out this investigation, the Independent Investigation Team has taken care to remain objective and impartial, whilst being mindful throughout of the devastating impact that this violent offence has had upon those most closely involved with it.

7.0 INVOLVEMENT OF MR A

7.1 At the commencement of this Investigation, Mr A was contacted by the East of England Strategic Health Authority in order to obtain his consent for the Independent Investigation to access his clinical records. Mr A subsequently signed a consent form giving the Independent Investigation Team full permission to access his clinical records.

7.2 The Independent Investigation Team Leader interviewed Mr A at HMP Gartree on two occasions. Mr A also provided a bundle of his own documentation dealing with the healthcare provided to him prior to and after sentencing.

8.0 PROFILE OF HERTFORDSHIRE PARTNERSHIP NHS FOUNDATION TRUST

8.1 Hertfordshire Partnership NHS Foundation Trust ('HPFT', the 'Trust') obtained Foundation Trust status on 1 August 2007.

8.2 HPFT provides specialist Mental Health and Learning Disability services for the people of Hertfordshire. It also has services in Norfolk and North Essex. HPFT provides both in-patient care and community services, providing Community Mental Health Teams (CMHTs) with specialist community teams for Assertive Outreach, Early Intervention in Psychosis, Crisis Intervention, and Child and Adolescent Mental Health Services (CAMHS). It employs approximately 3500 members of staff at over 100 sites.

8.3 HPFT is currently registered with no conditions and is fully compliant for all essential standards of quality and safety of service provision following a planned review by the Care Quality Commission.

8.4 HPFT organises its services into three geographical business streams:

1. Learning Disability and Forensic Services in Hertfordshire, Norfolk and Essex;
2. West Hertfordshire;
3. East and North Hertfordshire.

8.5 Each business stream is managed by two senior managers, one with a medical background at consultant level and the other with substantial health or social care management experience.

8.6 Overall, operational management of the Community Directorate rests with the Board of Directors of HPFT. However, the Independent Investigation Team understands that the Chief Operating Officer is responsible for the operational management of the services of HPFT, including both health and social care within mental health.

9.0 COMMUNITY MENTAL HEALTH TEAMS

9.1 CMHTs in Hertfordshire offer a specialist multidisciplinary service for individuals suffering with mental ill health. CMHTs form part of a planned and integrated whole system approach to care that is delivered in conjunction with in-patient, crisis and specialist services.

9.2 The Operational Policy for Community Health Teams (September 2005) (the 'Operational Policy') states that Community Mental Health Teams are committed to:

> *'**2 Purpose and Aims***
> - *Ensuring all health, social care needs and risk are assessed. That service users requiring a service are managed within the Care Programme Approach and an appropriate treatment/care plan and risk management plan agreed. The plan will include the views of the service user and relevant carers;*
> - *Providing services that are accessible to all sections of the local population including black and ethnic minorities*
>
> *...*
> - *Working with service users within a model of care that aids recovery and enables them to return to their full potential in day to day life*
>
> *…*
> - *Involving actively service users and carers in planning and delivering mental health services*
>
> *…*
> - *Working in collaboration with other statutory and voluntary agencies and ensuring the needs of the service user are taken into account.'*

9.3 CMHTs are based in all areas of Hertfordshire. Dacorum CMHT is based at St Paul's Mental Health Centre in Hemel Hempstead. St Albans CMHT is based at Edinburgh House, St Albans.

9.4 The Operational Policy states in relation to access to CMHT services that:

> *'5.1 The District of Residence of any person is sometimes difficult to determine. The guidelines below seek to address the issue and clarify lead responsibility for ensuring any dispute is resolved.*
>
> *5.2 During any period of time whilst a dispute is being resolved the CMHT that has received the referral must ensure the service user is offered an appropriate service and care is taken that the issue of the District of Residence does not delay any required treatment.*
>
> *5.3 If a period of treatment is commenced a Care Co-ordinator should be allocated and a when/if transfer is agreed this should be via the CPA process.*

5.4 If a person is a resident of Hertfordshire the District of Residence is normally determined by the GP practice where the person is registered. This rule however does not always apply. Many people, particularly on the boundaries of Hertfordshire, are living in a post code address which is in a different CMHT area to the GP practice where they are registered. When this is the case the service user post code will normally determine the appropriate CMHT to offer a service. This will be the CMHT local to the area in which the service user is living.

…

5.7 People of no fixed abode who are not registered with any GP practice become the responsibility of the CMHT providing the initial emergency care. It follows therefore that if the person assessed has to be transferred to an out of area contracted secure bed that person remains the responsibility of the Hertfordshire CMHT where the assessment took place.

5.8 If residence is unclear it follows that the 'responsible commissioner' for their care is difficult to identify. Responsibility to clarify the Responsible Commissioner rests ultimately with the CMHT manager of the locality where the service user was staying immediately prior to the referral for assessment.'

9.5 Mr A address prior to homicide

9.6 Mr A's domestic arrangements in the six months leading up to the homicide were disordered. The Independent Investigation Team have been unable to ascertain whether Mr A was formally resident at any address during this period. This led to confusion with different organisations, including different medical professionals involved in his care, the Multi-Agency Public Protection Panel, and the police, attempting to determine actions based on a number of temporary addresses.

9.7 Throughout this period Mr A was registered with a GP practice in Harpenden, which lies within the catchment area for the St Albans CMHT. However, Mr A received care from Dacorum CMHT throughout the period leading up to the death of the Deceased. The uncertainty concerning Mr A's place of residence is set out in the table below.

Dates	**Address**	**CMHT Catchment Area**
18 December 2006	Clarendon Rd, Harpenden	St Albans
8 January 2007	Noted to be living between Barnfield Rd Harpenden (mother's address) Woodhall Farm Hemel Hempstead (brother's address) & possibly other addresses. The MAPPP noted that his permanent address was unknown.	St Albans Dacorum

16 January 2007	Clarendon Rd, Harpenden	St Albans
27 March 2007	Harpenden (unaware of specific address)	St Albans
6 June 2007	Gorse Corner, Harpenden	St Albans
6 June 2007	Harpenden	St Albans

10.0 PREVIOUS MEDICAL HISTORY

10.1 Mr A has a complex medical history with a considerable amount of contact with a variety of agencies. A chronology setting out significant events in Mr A's previous medical history is set out below:

Event Date	Event Details
05 November 1997	Mr A was referred to Dacorum CMHT by his General Practitioner. The referral letter stated: '*I would be grateful for your assistance with this young man with multiple psychosocial problems leading to depression. He has asked for help for the first time. He is new to our practice and attends Drug Link with a cocaine and crack habit. He says this is a sporadic problem. He resorts to alcohol or drugs as a means of dealing with problems.'* A reply to this letter was sent on 26 November 1997 stating that following discussions with Mr A's caseworker at Druglink, it had been agreed that Mr A would continue counselling there without psychiatric assessment but that a further referral could be made if the GP felt it necessary.
20 January 1998	A referral to Dacorum CMHT by Mr A's General Practitioner. The referral letter stated: *'Mr A's Social Worker thought the case best handled by Druglink as this gentleman has a crack cocaine habit which surfaces periodically and leads to considerable social breakdown. Mr A appeared on the scene the other day in a very distressed state, obviously having been recently taking drugs, and requesting a note to excuse him from court, which in view of his mental condition I produced.[sic]* *...Mr A has considerable problems with depression related to childhood experiences including abuse from his father (who incidentally is in prison). Today he was extremely tearful, losing sleep and suffering from recurrent panic attacks. He experiences frequent suicidal feelings, especially in respect to a breakdown in his relationship with his wife, especially as they have a six-month old daughter. Recently I have discovered that his wife and daughter are now living in a refuge as they cannot cope with his unpredictable behaviour. Mr A continues to do what he considers to be useful work with Druglink. However, I am quite concerned about his underlying mental state and suspect with the recent demise of his domestic life he may be at some considerable risk to himself.* *I would be most grateful for an assessment by the psychiatric team as soon as possible, especially as the patient himself was very distressed that this had not been arranged in November last and is really keen to proceed along this route. Mr A is on no psychotropic medication. However I am fairly certain that his condition would be helped if this were instituted.'*
20 February 1998	Mr A's GP responded to a letter from Mr A's solicitors requesting a medical report. He noted that Mr A was due to be assessed by a Psychiatrist on 19 February 1998 but that prior to this Mr A had been admitted to hospital. The letter states:

Event Date	Event Details
	'*On the morning of 19 February, 1998 I received a phone call from Mr A's mother who informed me that Mr A had taken an overdose at 5.30 that morning. Allegedly he was in a very agitated state and refused to travel by ambulance to the hospital whereby the police were called and he ended up in hospital. His agitation continued and the police surgeon was called who attempted to assess Mr A but was unable to do so due to his agitated state.* *Subsequently he was transferred to Hemel Hempstead General Hospital whilst still in custody.* *I have spoken to the doctor who assessed him in Hemel Hempstead General Hospital Accident and Emergency Department. He informs me that initially Mr A refused both examination and blood tests. However, later, when his parents arrived he allowed examination and blood to be taken. Interestingly, the blood showed only a trace of paracetamol and no alcohol, making his story of overdose that morning very unlikely.'* Mr A's GP confirmed that a Consultant Psychiatrist assessment of Mr A would be important to help distinguish between mental illness and '*drug-related social breakdown'*.
23 November 1998	A Needs Led Assessment was completed. This included the following recommendation: '*Mr A's need would be met by a fixed term in residential rehabilitation followed by structured supportive aftercare within the area where he resettles. The project Mr A has chosen is in an area with extensive local facilities for follow-up support within the community. Mr A would be more likely to remain drug-free in an area where he does not know people*'.
01 December 1998	Letter sent from The Focus Project a community drug support group to Dacorum CMHT recommending residential rehabilitation. This letter stated: '*I am assessing Mr A for rehabilitation and am recommending residential rehab, which Mr A is also extremely keen for. Mr A has used a variety of drugs, mainly cannabis, crack cocaine and alcohol. He managed to stop using for a period of several months, but has drifted back to it over recent months.* *Mr A tells me that he feels he may have specific psychiatric problems underlying his drug misuse, which date back to how early life events have affected him. He would like to be assessed by a psychiatrist so that he can get the appropriate help. He has not had involvement with mental health services in the past so far as I am aware. I have not identified any mental health issues myself, but I have only met Mr A on three or four occasions for the purposes of the assessment*.'
07 January 1999	Letter from a Locum Psychiatric Registrar, to Mr A's GP. Letter described the following assessment of Mr A: '*I assessed Mr A on 7th January. The interview was reasonably difficult with Mr A being quite aggressive in his approach. He tells me that the reason that he has been referred was at his own request in an attempt to find an answer to the reason why he felt angry, suicidal, depressed and wanting to smash people up all the time. He tells that this has been an ongoing problem for the past seven*

Event Date	Event Details
	years, and even before then. *…* *He tells me that he last took cocaine approximately nine weeks ago and he is currently waiting to go into residential rehab. He does admit that he regularly uses a ¼ to 3/8 of an ounce of cannabis on a regular basis and does not feel he would be able to stop this.* *…* *His forensic history appears to have started approximately at the age of 13-14 and he was first imprisoned at the age of 15 in a Young Offenders' Institute. At the age of 17 he was given a 2 ½ year custodial sentence.* *…* *Mr A started his drug habit at the age of approximately 18-19. It started with cannabis and has now progressed to crack cocaine. He has never used drugs intravenously. His drug addiction has fuelled his criminality. He tells me that he drug abuses in binges rather than on a regular basis. He is currently using, as previously mentioned a ¼ to 3/8 of cannabis per week but denies using anything else, although he does say when he is not using drugs he tends to increase his alcohol consumption. He is currently drinking approximately 5-10 bottles of lager per day, most days, and tells me when he is on these binges his anger increases and he becomes more violent. He denies any withdrawal symptoms.* *…* *He has no past medical history of note and has no known allergies. He says he has seen a variety of prison psychiatrists but no one on a regular basis. He did admit that he tried to take an overdose approximately one year ago. His current medication is Venlafaxine, 37.5 mg once daily.* *…* *Mental State Examination – Mr A is a tall, casually dressed man who was accompanied by his wife. He was initially very angry in presentation. Eye contact was good but was perhaps slightly aggressive. Speech was of normal rate, rhythm and volume, although on occasions he did raise his voice when upset. His mood was objectively dysthymic and subjectively very depressed. There was no real evidence of any biological symptoms of depression. No psychotic phenomena were present and he had no suicidal intent at this time.* *…* *Formulation is of a 28 year old man with a long history of antisocial behaviour, including drug addiction and criminality on a background of extensive [sexual crossed out and a handwritten note added stating 'physical but not sexual abuse according to his last I/V on Oct 2. However his father having been convicted for sex [illegible]'] abuse. The plan is to continue with Druglink input and to attend the Residential Rehab, as previously arranged. He should continue with the psychotherapy he is receiving from the Focus Project. I do not feel that Mr A is suffering from any mental illness and I therefore question whether an antidepressant is of any use to him, particularly as the dose is so small. I will in the meantime refer him to Anger Management once he has undergone rehab. It may be worth considering whether or not psychology input could be useful to help him deal with the obviously difficult underlying personality issues.* *…* *I have made him a further appointment on 21st January 1999 before he goes to rehab in order to recap on what has been discussed here. During the discussion Mr A was very keen that a diagnosis should be given. I was unable to give him one and merely stated that what we are dealing with is underlying personality issues related to a background history of sexual abuse and the ongoing*

Event Date	Event Details
	problems.'
15 January 1999	Letter from Consultant Psychiatrist at Dacorum CMHT to Mr A's GP. The letter stated: *'I agree entirely with a locum registrar's formulation of Mr A as having a history of antisocial behaviour, drug addiction and criminality, without evidence of severe mental illness. His current use of alcohol is a contra-indication to his being involved in any form of therapeutic work, except possibly focused work to help him to cut down and control his drinking. I think his capacity for acting out is very high, particularly if his very fragile ego defences were challenged. For this reason I would advise against his being considered for any form of residential rehabilitation until he has shown the capacity to control his aggression. I would advise any worker who saw him to ensure that adequate safety and alarm systems were available to summon help.* *I think it is important to obtain a forensic psychiatric assessment both with a view to confirming the diagnosis and giving advice on management. I will write to Mr A to inform him that I am asking for a further specialist opinion, and cancelling his appointment for 21st January.'*
22 February 1999	Report from a Specialist Registrar in Forensic Psychology to Consultant Psychiatrist at Dacorum CMHT: *'Mr A does not currently suffer from mental illness, including a depressive disorder. Mr A is handicapped by lifelong personality difficulties, which are understandable from his family and early background, which included parental physical and sexual abuse, about which he is very sensitive and easily becomes angry, and his parents early introduction of him to alcohol as a child and his temporary separation from his parents when taken into care due to their abuse of him. His personality difficulties are characterised by a low self-esteem, over-sensitivity, impulsivity, difficulty sustaining inter-personal relationships and employment, a low tolerance of stress, following which he has a liability to intemperate outbursts of anger, to become disproportionally despondent, to abuse alcohol and drugs to counter his personality difficulties, the limitation these place on his life, feelings of despondency and negative feelings about his past abuse by his parents.'* He suggested that Mr A may benefit from anger management counselling once his substance and alcohol abuse was controlled.
July - September 1999	Mr A offered residential treatment at Yeldall Manor. Mr A refused residential treatment due to ongoing court case. Mr A noted to not have a mental illness by Social Workers and was referred back to the Focus Project on 11 August 1999. Mr A next made contact with Focus in September 1999.
03 February 2000	Pre-sentence report written by Mr A's Probation Officer. Mr A was noted to have made considerable improvements in his lifestyle but still acted impulsively and recklessly. He consistently provided negative drug tests for amphetamine, cocaine, methadone and morphine. He remained at risk of re-offending.

Event Date	Event Details
	Mr A was recommended Probation for eighteen months to allow therapy to continue. A referral to the Intensive Probation Programme had been made by Mr A's Probation Officer but she did not think that this would be suitable due to Mr A's psychological problems.
07 February 2000	Psychiatric assessment at Hemel Hempstead General Hospital following an overdose of Dothiepin, Diazepam, Paracetamol and alcohol. Mr A noted to be non-co-operative on admission. On the day of the overdose Mr A claimed to have drunk 15 pints of lager. His blood alcohol level on admission was 133mg/100ml. He admitted to consuming 2oz cannabis per week but denied crack abuse for 1.5 years. '*No evidence of thought content disorder, no pathological perception. Very angry and tense, subjectively feeling disappointed and distressed. Says he still harbours suicidal ideas of overdoses with alcohol, but objectively he presents this clearly with a blackmailing connotation. No evidence of acute cognitive impairment, orientated to time, person, situation and place. Says he wants to get psychiatric input asap. Discussed with Consultant Psychiatrist at CMHT– well-known patient with emotionally unstable personality disorder. Rapport always very difficult. No new evidence for increased and altered risk of DSH justifying admission to a psychiatric hospital, also with a view to his blackmailing attitude*.' Mr A was discharged and provided an outpatient appointment at Dacorum CMHT on 21 February 2000. He was also recommended alcohol counselling at the Focus Project.
17 January 2001	Mr A assessed by a Locum Consultant Psychiatrist at Hemel Hempstead Police Station following arrest for causing serious damage to his flat, including tearing out radiators.
19 January 2001	Inter-agency risk management meeting took place including police, Housing Department, Psychiatrists and Probation. Risk management plan agreed. Mr A to be entered on Public Protection Register. Probation, Police, Housing, Health and Social Services to work together regarding the matter. Psychiatric Assessment to be obtained.
21 March 2001	Pre-sentence report completed by Probation Officers (in relation to criminal damage to Mr A's flat, drunk and disorderly behaviour, threats to destroy property at his address, and theft of DIY items). Report includes the following: *'It was depressing to see how much better he looked in prison and how much calmer he appeared having been freed from the stresses of managing his life in the community. He takes his medication (Ritolin[sic]) regularly which aids his concentration: he attends the gym and educational classes and, at the time of my visit, was in the process of setting up a self-help group for inmates.'* The Probation Officer noted that a Probation Order with a condition of psychiatric treatment could not be proposed as medical opinion suggested that Mr A did not have a treatable mental illness and so there was no named psychiatrist prepared to undertake the treatment.
12 October 2001	Psychiatric assessment of Mr A carried out at Dacorum CMHT. Report includes the following:

Event Date	Event Details
	'*Mr A requested help regarding ways to tackle long standing problems, like for instance his anger and he is[sic] violent and sometimes self destructive behaviour`.* *…* *He admitted to occasional episodes of bingeing alcohol (15 pints of alcohol during most weekends), but he denied any other use of drugs apart from Cannabis which he consumes regularly, as he finds it helpful (thinks it relaxes him and calms him down).* *Clinical Presentation: He appeared to be slightly hypomanic (there was pressure of speech). He denied any sleep or appetite disturbances and he described his main current problem being his long standing agitation/anger/boredom if he doesn't occupy himself.* *…* *Long standing personality difficulties in a young man with difficult childhood, and a past history of drug and alcohol abuse. No evidence of mental illness at the time of assessment.* *…* *He was discussed with Social Worker and it was agreed that he would be granted a referral to the department of psychotherapy for an assessment which was his explicit request during all three consultations.'*
19 December 2001	Social Worker completed a Community Mental Health Centre assessment. He reported that due to his history Mr A presented a serious danger to the community at large. This view was shared by other agencies including housing, probation and police. His perception was that there was a need for extended assessment to consider this and seek guidance from colleagues or a supervisor.
12 April 2002	Psychologist at Dacorum CMHT contacted Consultant Psychiatrist 1 informing him that Mr A had failed to present for an appointment in February 2002 and had failed to take up anger management services. He also noted that they were closing Mr A's file due to his failure to engage.
14 May 2002	Letter from Social Worker to various parties inviting them to a meeting regarding Mr A due to the escalating levels of risk to himself and others. At this time Mr A is described as being of No Fixed Abode. His apparent levels of drink and drug misuse, together with offending behaviour, were noted to be escalating.
23 May 2002	Mr A admitted to hospital informally. He was noted to have '*past Hx*[sic] *of personality disorder*' in the risk assessment carried out on admission. He was entered in the admission record as being under the care of Consultant Psychiatrist 1. Mr A noted to have appeared angry during assessment and claimed to have had very little support for the last 9 months. On the second day he felt edgy and wasn't sure whether this was the right environment for him. On speaking to a key worker he stated that his drug and alcohol abuse had only started when he found out that sexual offences had occurred in his family. On the third day he was irritable and angry, demanding his medication but later apologised to staff. On the fourth day nothing remarkable was noted on his records. On the final day Mr A was informed he was to be discharged with no medication and became violent as below.
27 May 2002	Whilst being reviewed at St Julian's by Consultant Psychiatrist 1, when Mr A was

Event Date	Event Details
	told he was to be discharged he became verbally and physically abusive. He smashed a cup, threatened suicide and attempted self-harm with the broken cup, spat at Consultant Psychiatrist 1, and threatened to follow and kill him. The police were called and Mr A arrested. Mr A was discharged into police custody with no medication. The discharge letter notes that he had '*no mental illness, social problems*'.
28 May 2002	Guidelines set out for dealing with Mr A were discussed relating to this care at CMHT. It was agreed that Mr A was to be presented to MAPPP meeting. Noted that forced admission under Mental Health Act 1983 was not possible as Mr A had an untreatable personality disorder rather than being mentally ill. Following this meeting an undated memo by Consultant Psychiatrist 1 appears to have been circulated to West Hertfordshire Hospital, St Julian's and Albany Lodge. It stated in relation to Mr A: *'Please take note, that the above mentioned gentleman has a violent character and a long forensic history. Recently he assaulted myself and was extremely intimidating and threatening. He is* ***NOT*** *mentally ill and therefore discharged from the Mental Health Services. However, he is in the habit of presenting himself with parasuicidal gestures usually triggered by external events (court appearances, desperate for accommodation, intoxicated altercations etc).* ***DO NOT ADMIT HIM****; he is banned from St Julian's due to his aggressive behaviour. His social worker at St Paul's in Hemel Hempstead will only see him under strict controlled and safe conditions.'*
June - July 2002	Correspondence between Community Mental Health Nurse from the Assertive Outreach Team, Social Worker and Specialist Registrar in Forensic Psychiatry who had interviewed Mr A at HMP Woodhill. At this time, Mr A was on remand for several charges including one of assault on Consultant Psychiatrist 1. The discussion was in relation to a placement at the Henderson. Mr A had previously declined an offered placement but had re-considered. Mr A was instructed to contact '*his CMHT'* when next at liberty.
19 December 2003	Mr A reviewed at CMHT. Mr A had commenced anger management sessions and claimed to have been off all drugs for one year and to not be drinking alcohol. His records state: '*His diagnosis is one of a personality disorder with dissocial traits and poor anger and impulse control. He functions well in prison with boundaries and activities in place and needs this structure in the community*.' Mr A to be reviewed in 2 months and followed up in the community.
11 May 2004	Letter from CMHT to Mr A's GP notifying him that as Mr A had failed to attend an appointment on 7 May 2004 he was being discharged. Letter states: *'I have discussed this issue with my Consultant, Consultant Psychiatrist 1 and we were of the opinion that as he doesn't suffer from any major mental illness with no regular medication. Hence we will discharge him back to your care for further follow up, but would be happy to see him again if the need arises in the future.'*
28 May 2004	Letter from Consultant Psychiatrist 1 to Mr A's GP following a review of Mr A's

Event Date	Event Details
	needs in the presence of his partner.
13 October 2004	Mr A reviewed at CMHT by Consultant Psychiatrist 1. '*He told me that he has not been taking drugs for six or seven years and not taking alcohol regularly. He, however, admits that he might lose control when he binge drinks. He felt that medication was helping him; also the anger management course he is doing. He is seeing his probation officer once a week*'. Mr A complained of housing issues and lack of access to his daughter, as well as wanting to access his own files with social services.
01 April 2005	Multi-Agency Public Protection Panel Meeting (MAPPP) held. As a result of Mr A being involved in several incidents of violence against his partner, her daughter had been placed on the at risk register. It was decided at the meeting that Mr A should be registered at level 3 (risk of imminent harm). As part of the protection plan it was requested that Dacorum mental health services re-assess his mental state and if indicated prescribe medication which may reduce his impulsive and aggressive behaviour. It was also agreed that consideration would be given to a 'risk of harm assessment' by a psychiatrist, which Probation Services agreed to fund.
5 April 2005	CMHT referred Mr A to Forensic Psychiatrist for a 'Risk of harm assessment'.
25 April 2005	Letter from Dacorum CMHT, Consultant Psychiatrist 1 to Consultant Forensic Psychiatrist 1 requesting a forensic review and advice on future management. *'In my opinion he is not mentally ill but suffering from a psychopathic disorder and poor impulse control. I have commenced him on Quetiapine 125 mgs daily since May 2004 to help him contain his anger and as far as I know he has been compliant in taking this drug. He is still a bit of a loose canon[sic] in the community in particular because he continues to drink alcohol albeit according to his account in moderation*.'
21 June 2005	Mr A examined by Consultant Psychiatrist 1 at St Paul's, Dacorum CMHT. The results of this examination showed: *'His main problem at the moment is insomnia, mainly caused by intense boredom, due to a lack of a structured day programme.* *…* *Mr A told me that since he left prison three months ago he has not been in any kind of trouble. He has cut down on the alcohol intake and is smoking less cannabis during the week. In actual fact both he and his partner have cut down on the booze and it is my understanding that they are going to see Relate for couple counselling. Mr A is also receiving alcohol counselling based at Watford Probation Centre. He attends weekly.'* Mr A was also noted to be refusing to see Consultant Forensic Psychiatrist 1 due to an unwillingness to be classified as a forensic case. Consultant Psychiatrist 1 noted '*…he impressed me as being quite paranoid about the appointment*'. Mr A requested that a CPN be assigned to him but Consultant Psychiatrist 1 noted that the resources were not available for this.

Event Date	Event Details
	Plan for Mr A to be reviewed in two months.
21 June 2005	Review by Consultant Psychiatrist 1. Mr A seen in presence of his partner.
11 July 2005	Mr A presented to A&E department with *'nightstick type injury of left ulnar'* and had a cast fitted.
01 August 2005	Application for revocation of probation. At the time of writing the report, Probation Officer stated that Mr A was effectively homeless and injured which had meant that he was unable to attend appointments (between 11 April - 13 July 2005 a total of 9 appointments with a variety of services had not been attended). She stated that supervision was not viable as a result of Mr A's health and accommodation difficulties and requested a revocation.
26 September 2005	The Chair of West Hertfordshire MAPPP wrote to Consultant Forensic Psychiatrist 1 regarding his report of 21 September 2005. He noted that Consultant Forensic Psychiatrist 1 had not addressed Mr A's assessment as 'high risk' by the MAPPP and asked four specific questions regarding this assessment: *'1. In your opinion does Mr A represent a current risk of serious harm towards his partner?* *2. In your opinion does Mr A represent a current risk of serious harm towards the wider public?* *3. Does Mr A exhibit characteristics of an anti-social personality disorder? If he does, are these characteristics linked to his violent behaviour and are they in any way treatable?* *4. Do you have any advice regarding any psychiatric input that could help address Mr A's violent behaviours within the context of a multi-agency risk management plan?'* Consultant Forensic Psychiatrist 1 responded to this letter as follows: *'Thank you for your letter of 26 September. I believe my letter of 21 September to the Probation Service addresses all the points you raise questions on.'*
4 October 2005	Mr A failed to attend an appointment with Consultant Psychiatrist 1. Mr A was offered another appointment on 18 October 2005.
18 October 2005	Mr A reviewed by Consultant Psychiatrist 1 in the presence of his partner.
20 October 2005	Mr A reviewed by Consultant Psychiatrist 1 at St Paul's, Dacorum CMHT. Consultant Psychiatrist 1 noted that Mr A was *'despondent'* about the suggested psychometric testing and said that he would refuse to co-operate with an assessment. Consultant Psychiatrist 1 noted that Mr A would be being seen by Consultant Forensic Psychiatrist 1 and that he would review Mr A in three months.
24 October 2005	An addendum to the Probation Revocation Application was produced. This noted that Mr A had attended all Probation appointments as required and repeated the view of Probation Services that:

Event Date	Event Details
	'…He is not willing and possibly not able to engage with Probation supervision at the level necessary fundamentally to alter his attitudes or behaviour. It remains to be seen whether he can do so in work with other agencies, but structured help is on offer from various sources.' It was recommended that the Probation order be revoked.
24 October 2005	A Psychological Risk Assessment Report on Mr A was produced by a Forensic Psychologist at the request of the Hertfordshire Probation Team. It was concluded that there was a medium risk of Mr A reoffending in a violent manner and recommended that he take part in an established domestic violence group as well as further work to explore his anger and emotional control.
9 November 2005	Mr A attended an appointment with Consultant Forensic Psychiatrist 1 in the presence of his partner at Dacorum CMHT. Consultant Forensic Psychiatrist 1 concluded that Mr A was treating his efforts to obtain help seriously. Mr A asked for help in dealing with the risk of aggression in his relationship with his partner. Consultant Forensic Psychiatrist 1 concluded that his role was: *'To follow on from the risk issues raised by the MAPPA, and achieve a clearer formulation of his risk in the context of any personality abnormalities.* *To explore attitudes and situations around risk of aggression and violence in their relationship.* *I intend for my current contact with Mr A to be time-limited, anticipating a three-weekly to monthly meeting for up to about three or four months. In clinical terms, this is less about treatment than it is about informing our formulation of his needs as well as informing his own insight.'*
04 January 2006	Mr A failed to attend an appointment with Consultant Forensic Psychiatrist 1. In a letter to Consultant Psychiatrist 1, Consultant Forensic Psychiatrist 1 noted: '*As you know, he could not make the appointment. I am nevertheless satisfied that it is appropriate to bring to an end my planned time-limited series of meetings with Mr A.* *…* *There have been no issues about violence either within the relationship or in relation to others. Mr A has adopted a positive approach to addressing what he sees as his needs, and I am encouraged by what he is achieving, given that it has been a short time since his last prison release.* *…* *Please note that my sessions did not involve anger management. I addressed the objectives I set out in a previous letter to you*.'
31 January 2006	Mr A was reviewed by Consultant Psychiatrist 1 in the presence of his partner.
02 February 2006	Mr A was reviewed by Consultant Psychiatrist 1 at St Paul's, Dacorum CMHT. Letter from Consultant Psychiatrist 1 to Mr A's GP. Letter stated: *'Mr A has a diagnosis of anti social personality disorder and impulse control problems, in particular when under the influence of substances. He is from a traveller background and has a criminal record. Mr A was subject to a probation order with a condition to have regular reviews by his psychiatrist. He is not on probation anymore but he is still seeing me on three monthly intervals. He is not*

Event Date	Event Details
	suffering from a mental disorder and is not on any prescribed medication by me. *Action Plan:* *I will remain the RMO for Mr A for the foreseeable future because Mr A has difficulty trusting people and we go back a long time. Mr A can come across as intense and forceful, but I do think that he is trying to make a genuine attempt to make things work with him and his partner. I will review him again in three months time*.'
28 February 2006	Report by Consultant Psychiatrist 1 at the request of Mr A's solicitors. The report stated: *'Mr A is known to the Dacorum Mental Health Services since November 2007 diagnosed as suffering from anti social personality traits, poly substance misuse, poor impulse control under unfavourable circumstances and a tendency towards aggressive acting out…with regards to his mental health problems no formal psychiatric disorder has been identified.* *…* *I will remain his responsible medical officer for the foreseeable future offering continuity and consistency of care based on a four year history with me.* *Prognosis* *In my opinion Mr A remains a vulnerable adult in the community, who remains at risk of a relapse to impulsive self destructive behaviour under adverse circumstances…Personally and professionally I am of the opinion that Mr A has the potential to overcome his personality difficulties provided he learns how to control his temper and stays off the alcohol.'*
3 April 2006	Letter from Consultant Psychiatrist 1 providing an additional note regarding Mr A's ongoing risk at the request of Mr A's solicitor. The note stated: '*It is my professional opinion that Mr A has done very well over the past 12 month, attending to the outpatient appointments with myself correctly and behaving appropriately in my office. I always see him on my own and have not felt threatened nor intimidated in any way. We were able to discuss sensitive issues in some depth and Mr A contained his emotions well.'*
11 April 2006	Letter from Consultant Psychiatrist 1 to Mr A's GP following an urgent review at Mr A's request following ongoing issues with Children Schools and Families. The letter stated: '*Mr A gave me a subjective account of feeling physically sick and emotionally crumbling due to the ongoing stress caused by the fight with Social Services. Objectively I found him more or less the same as usual speaking forcefully but all within reason. He is not psychotic and in my opinion not clinically depressed. I do acknowledge that he is under a lot of strain.* *…* *Action Plan:* *There is not much I can do at this stage for him…Mr A has an appointment to see me again on the 2 May 2006*.'
2 May 2006	Mr A failed to attend an appointment with Consultant Psychiatrist 1 at his clinic at St Paul's, Dacorum CMHT.

10.2 During this period a number of reports were compiled about Mr A as a result of his contact with mental health, social services and the criminal justice system.

10.3 Specialist Registrar in Forensic Psychiatry, 22 February 1999

10.4 This report was prepared for Dacorum CMHT. In compiling the report, Mr A was interviewed on one occasion.

10.5 Mr A's past psychiatric history was recorded as follows:

> *'Mr A said that we had been seen by psychiatrists during custodial sentences, in particular when he was a youth in Feltham Young Offenders Institution. I believe this assessment was for his drug abuse.*
>
> *Mr A said that approximately one year ago he took an overdose of the night sedative Zopiclone tablets, alcohol and crack cocaine, he said that he was feeling depressed and suicidal at the time but did not describe a clear precipitant to this overdose. It appears that Mr A was also behaviourally disturbed on this occasion and broke furniture and kicked and broke one of the doors in his house. I believe on this occasion he also assaulted his wife, although I am not clear whether she sustained an injury which required hospital treatment.'*

10.6 In relation to drug and alcohol history, it was stated:

> *'Mr A said that he drank alcohol from early childhood. He said this was normal within his close and extended family. He said that he has continued to use alcohol since then. He denied being physically dependent upon alcohol, although he admitted to abusing alcohol to excess. He denied features of tolerance, dependence and withdrawal from alcohol in the past, including increasing his intake, drinking alcohol in a stereotyped fashion or in the morning to relieve physical symptoms of withdrawal.*
>
> *Mr A admitted to using cannabis and cocaine, he said that he first abused cannabis from the age of approximately 18. He mentioned to me that he has used cannabis on a daily basis in the past. He said that he progressed from cannabis abuse to using cocaine and has recently moved onto crack cocaine. He said that he began to use crack cocaine on a daily basis approximately 4 years ago and has increased his intake since then. He described feeling psychologically dependent on cocaine because of his daily use. He said that he has, on two occasions, smoked heroin, but has found this unpalatable.'*

10.7 On his circumstances at the time, the following was noted:

> *'I understand that Mr A and his wife separated after an incident approximately a year ago when he acted violently towards her. Since that time Mr A has described a gradual change in his attitude towards his substance misuse. He*

has said that he has realised that he should become abstinent and has requested support in this process. He has not described a profound and sustained depression of mood during this time. He has described, though, feeling frustrated and upset when he has been unable to progress his attempts to become abstinent. He said that in the last few months, he has markedly reduced his drug intake. He said that he now only occasionally drinks alcohol or takes illicit drugs.'

10.8 It conclusion, it was felt that:

'Mr A is handicapped by lifelong personality difficulties, which are understandable from his family and early background, which included parental physical and sexual abuse, about which he is very sensitive and easily becomes angry, and his parents early introduction of him to alcohol as a child and his temporary separation from his parents when taken into care due to their abuse of him. His personality difficulties are characterised by a low self-esteem, over-sensitivity, impulsivity, difficulty sustaining inter-personal relationships and employment, a low tolerance of stress, following which he has a liability to intemperate outbursts of anger, to become disproportionately despondent, which resulted in him taking an overdose of the night sedative Zopiclone about 1 year ago, to abuse alcohol and drugs, including cannabis and crack cocaine to counter his personality difficulties, the limitation these place on his life, feelings of despondency and negative feelings about his past abuse by his parents.'

'Once his substance abuse is controlled, he may benefit from further counselling or more in depth psychotherapy to address issues from his family and early background, including his abuse by his parents, which has resulted in his current personality difficulties, especially his low self-esteem and difficulties in inter-personal relationships.'

10.9 Summary of Psychiatric Assessment prepared by a Locum Staff Grade Psychiatrist to Consultant Psychiatrist 1, 11 December 2001

10.10 This assessment was carried out following a referral to Dacorum CMHT by Mr A's social worker at Mr A's own request. It was reported that:

'Mr A requested help regarding finding ways to tackle long standing problems, like for instance his anger and he is violent and sometimes self destructive behaviour….

He admitted to occasional episodes of bingeing alcohol (15 pints of alcohol during most weekends), but he denied any other use of drugs apart from Cannabis which he consumes regularly, as he finds it helpful (thinks it relaxes him and calms him down).'

10.11 With regard to his clinical presentation at that time, the following was noted:

'He appeared to be slightly hypomanic (there was pressure of speech). He denied any sleep or appetite disturbances and he described his main current problem being his long standing agitation/boredom if he doesn't occupy himself.'

10.12 In relation to drug history, it was stated that:

'At the age of 13, he started smoking Cannabis and between the ages of 18 to the age of 28 he used to be heavily involved with crack cocaine. According to his report he has consumed huge quantities throughout his life but he stopped two years ago, and he denied ever having used any drugs intravenously.'

10.13 The following forensic history was noted:

'In 1997 he was imprisoned for criminal damage for a year, as he had smashed a pub. His most recent imprisonment was for having smashed his flat and having attacked a taxi driver.'

10.14 The conclusion appears to be that:

'Long standing personality difficulties in a young man with difficult childhood, and a past history of drug and alcohol abuse. No evidence of mental illness at the time of assessment. The main identified problem by himself namely his anger and impulsivity was openly displayed during our consultation when I informed him that he would have to be on a waiting list for a key worker and that our review appointment would be in five weeks time. He found this outrageous and not good enough and behaved as someone who was being attacked. He failed to attend the next appointment stating that the notification for the appointment date was sent to the wrong address. (However it was sent to the address he had confirmed as his sisters address during his first appointment). Following that he did attend two successive meetings with Social worker, during which he appeared to be in a conciliatory mood, but then again he cancelled the third and supposedly final appointment stating that he could not attend because he was ill. He was discussed with Social Worker and it was agreed that he would be granted a referral to the department of psychotherapy for an assessment which was his explicit request during all three consultations.'

10.15 Psychiatric Report prepared by a Specialist Registrar in Forensic Psychiatry, 25 October, 2002

10.16 Of Mr A's personal history, it was stated that:

'He told me that he was frequently distracted and bored at school and was mostly not there.'

'He told me he had returned to the family unit after his father was released from prison. He however left home at the age of about fifteen or sixteen to stay with his friends, engaging in petty thieving as well as drugs and alcohol.

Mr A told me that between 1986 and 1991 (aged fifteen to twenty years) he got himself into lots of trouble involving heavy use of crack cocaine, ending up in a four year prison sentence in 1991.'

10.17 The issue of Mr A's psychosexual history was explored:

'Following contact with his older stepbrother in 1996 he became aware of incidents of sexual abuse within the family. This did upset him a great deal and he resumed alcohol and crack cocaine use. This led to a number of difficulties including frequent arguments with his wife as well as the failing of his business. His alcohol and drug use led him into trouble and he ended up in an eighteen month custodial sentence for affray…. He told me he got himself into debt totalling £78,000.

Mr A told me he that when he turned thirty years of age he realised he had lost everything in his life, his wife, his daughter, and his pet dog. He tried reconciliation with his wife, but this failed. He again resumed heavy alcohol use. He told me that he did smash his flat up at the time in distress asking for help, but got no help. He acknowledged his anger and aggressive behaviours, stating "I don't want to hurt anyone, I want to sort out my life and be there for my daughter".

Regarding his personality, he described himself as always hyperactive and trying to please others. He said his life was full of anger. He told me his friends would describe him as having unpredictable moods, and that he loses his temper over trivial issues. His friends would describe him as "wild" when he lost his temper.'

10.18 Mr A's past psychiatric history was noted to include:

'Mr A told me he was recently admitted voluntarily to St Julian's Ward at St Albans but was discharged five days later on account of not having a treatable mental illness. He told me that in his attempt to avoid discharge he self harmed by cutting his left arm with a broken glass as a last minute attempt to avoid discharge. He said that soon after his discharge he got himself into various troubles, including eleven charges of affray and criminal damages.'

10.19 In relation to the circumstances at the time of the alleged offences (criminal damage, threats to damage property and affray), it was noted that:

'In June 2002 Mr A had been at the same public house whilst under the heavy influence of alcohol and threatened to fire bomb the place. He had argued, he was drinking heavily, and was not in control of his actions.

The affray charges occurred when he had been drinking heavily for two days. He was assaulted by another customer (hit on the head with a hammer) at the Royal Stag public house. He told me that he had no recollection about what followed the assault because of his alcohol intoxication and concussion from the head trauma.

However, Mr A remembered throwing things about including ashtrays in a fit of anger. Ten minutes later he walked into a nearby public house, The Greenacres, and started causing similar damage like before. I noted from the draft probation report that his behaviour in both incidents did inspire great fear in those present in the public houses.'

10.20 It was noted that Mr A might benefit from the following care:

'Mr A described difficult, unstable and disruptive formative years. His history is suggestive of childhood experiences of abuse within the family. Mr A appears to have long standing psychological problems in relation to the above experiences….

His behaviour predominantly characterised by liability to anger and violence, impulsivity, unstable and unpredictable moods. These elements of behaviour are consistent with an emotionally unstable personality disorder – impulsive sub-type. He therefore has the propensity of sudden unrestrained anger, and high levels of aggression impulsivity when he has perceived to be wronged or thwarted.'

'The evidence is that it is probably best to avoid hospitalisation to an acute psychiatric units for individuals with this type of disorder. Pharmacotherapy (drug treatment) is of limited usefulness. Treatment is based on long term outpatient commitment to various therapies including individual psychotherapy, group therapy or long term milieu therapy like that provided at the Henderson Hospital and at times in a day hospital set up.'

10.21 The Henderson Hospital is a residential Therapeutic Community and Outreach service offering treatment to up to 29 people aged between 18-60 who have been diagnosed with personality disorders.

10.22 It was concluded that:

'He does not suffer from a mental disorder within the meaning of the Mental Health Act 1983. His behaviour and characteristics fits a diagnosis of emotionally unstable personality disorder – impulsive sub-type. This disorder does not amount to a psychopathic disorder within the meaning of the Mental Health Act 1983.'

10.23 It was also stated that:

> *'Mr A is requesting to be re-referred to the Henderson Hospital. I believe this is an appropriate way forward and would suggest this is organised through his new General Practitioner and local Community Mental Health Team when next at liberty.'*

10.24 Psychiatric Assessment prepared by Consultant Forensic Psychiatrist 1, Consultant Forensic Psychiatrist 21 September 2005

10.25 This assessment was carried out on behalf of the Hertfordshire MAPPP with the agreement of the Probation Service. Consultant Forensic Psychiatrist 1 met with Mr A and his partner at Dacorum CMHT in Hemel on 21 September 2005.

10.26 Consultant Forensic Psychiatrist 1 recorded that:

> *'Mr A spoke at length about wanting a "game plan" to help him sort things out, In terms of occupation, family life and emotional wellbeing. He asked about anger management. He said he wanted to resolve all his issues while remaining in the community and living with his partner, not to be placed in any residential therapeutic setting. In this regard, he was not keen on my thoughts around a setting such as The Henderson, where inpatients are voluntary and not expected to be on criminal or detention order.'*

> *'Mr A spoke about his "paranoia" and acknowledged his tendency to feel that the legal systems in particular were making things difficult for him on account of his criminal and prison record. He acknowledged my observations – in his history – that he had a tendency to being sensitive to criticism, and not reacting very well when he perceived others actions or words as not being fair on him, or hindering him.'*

10.27 Consultant Forensic Psychiatrist 1's assessment of risk based on the meeting was:

> *'medium for severity of behaviour, and low for immediacy. In other words, I recognise his historical propensity for aggression, taking account of his personality characteristics, but his current circumstances, do not suggest any aggravating factors that would lead him to manifest this aggression in the immediate future.'*

10.28 Consultant Forensic Psychiatrist 1, in his recommendations, stated that:

> *'I am not recommending any order under the Mental Health Act 1983 – Mr A is not in need of hospital treatment at this stage. I have however shared with Mr A my early thoughts about a therapeutic setting such as The Henderson, which provides a structured environment without the potential distractions he would have to deal with in the community. This needs to be explored with him overtime, and it will depend on how he manages his current time out of prison.*

Likewise, I would not recommend that Mr A is compelled to attend for any psychometric testing – that he has a history of problems in personality development is patently obvious….'

10.29 Consultant Forensic Psychiatrist 1 noted in relation to the on-going care of Mr A:

'Two thoughts come to mind:

- *My team and I would be happy to discuss with probation service ways of improving the kind of input – from a mental health perspective – Mr A receives when he is compelled to attend probation service. As I have recently discussed with probation, we are interested in enhancing our partnership working with the probation service.*
- *I would like to discuss with Consultant Psychiatrist 1 the possibility of my seeing Mr A perhaps for a series of appointments, partly because I think Mr A and I could do useful exploratory work together, and partly because I would like to better appreciate the longitudinal picture. At the same time, I will discuss with Consultant Psychiatrist 1 the psychological resources available in the community service, although I know that these are stretched.'*

10.30 Psychological Risk Assessment Report prepared by a Chartered Forensic Psychologist, October 2005

10.31 A Forensic Psychologist was approached by Hertfordshire Probation Team to complete a PCL-R (psychopathy checklist) assessment on Mr A. This was to form part of their application for revocation for Mr A. The PCL-R is essentially used as a diagnostic tool to identify the presence of psychopathy or psychopathic traits.

10.32 In addition, it was also felt suitable to complete the Violence Risk Appraisal Guide (VRAG) in order to fully consider the likelihood of Mr A committing further acts of violence and the potential risk he may pose should he remain in the community. A PCL-R score contributes to a VRAG assessment.

10.33 Due to various reasons, the assessment was carried out without an interview and was based on file information and reports from other professionals who had the opportunity to meet with Mr A.

10.34 In relation to Mr A's poor behaviour controls, it was noted that:

'Mr A's index offence is of ABH against his current partner. This offence suggests loss of emotional control, displayed through violence. Mr A has a range of violent offences of a similar nature that have occurred as a result of him being unable to manage his emotions. Mr A damaged his council property causing thousands of pounds worth of damage in response to the break up of

his marriage. Mr A describes going through a mental break down at this time where he was unable to control his emotions. Mr A also reported a history of unpredictable moods. Professionals have reported that at times Mr A has demonstrated an ability to control his mood level.'

10.35 In relation to lack of remorse or guilt the following was noted:

'Mr A appears to place blame for his offending behaviour on his drinking and as a result of adverse circumstances….Mr A does not appear to have displayed a significant amount of sincere remorse for other behaviours such as the damage he caused to his own council flat and the homes of others, or for other violent and non-violent offences he has committed in the past.'

10.36 In assessing failure to accept responsibility for own actions, it was noted:

'Mr A originally denied committing the current assault against his partner, however he later admitted to this. Mr A has been observed to provide inconsistent accounts of his drinking patterns to professionals, claiming on one occasion that he had a drink on one particular day, only to state later the same evening that he had not drunk for several weeks. Mr A often places blame for his violent offending behaviour for his drinking and on adverse circumstances. When discussing the damage he caused to his council property, he appears to justify this by stating that he was going through a mental break down after the end of his marriage. Mr A indicted in the past that the Probation Service are not fully protecting the victim from his index offence from him. He also believes they are responsible for sorting out his housing although he made himself intentionally homeless by leaving home through fear for his safety.'

10.37 The result of the VRAG was that:

'Mr A's assessment indicated that he falls within the third highest category. This would suggest that 55% of violent offenders who fall within this category are likely to re-offend in a violent manner within the next seven years and 64% within the next 10 years. This would indicate that there is a medium to high risk that Mr A will violently re-offend within the next ten years, however, the tool is unable to distinguish between domestic and stranger violence.'

10.38 The following conclusion was reached:

'Mr A's overall score for the PCL-R was 22.4/40. This indicates that he falls within the 50th percentile as compared to other male offenders, suggesting he would score higher than 50% of other male offenders. This would place him as having moderate levels of psychopathy and indicates the presence of some psychopathic traits, although a full diagnosis may not be made. Mr A demonstrates specific concerns in the areas of poor behaviour controls; lack of remorse/guilt; irresponsibility; failure to accept responsibility for own actions; revocation of condition release; and criminal versatility. To a lesser degree he also demonstrates concern in the areas of a need for stimulation, manipulation,

lack of empathy, parasitic lifestyle, early behavioural problems, impulsivity and juvenile delinquency.

…

Given the scores for the PCL-R and the VRAG, there is evidence to suggest that there is a medium risk that Mr A will offend again in a violent manner. Although the tools do not differentiate between domestic and stranger violence, Mr A's history would indicate that he may be at risk of committing either. Given Mr A's past offending behaviour and risk assessment scores there are a number of situations that are likely to increase the likelihood of him committing further violent offences. Predominantly, misusing alcohol and drugs has been highly associated with past violent offences and therefore would place him at a greater risk of offending in the future. Although Mr A is no longer using crack cocaine and has accessed an alcohol misuse group, he has openly admitted to occasional use of alcohol and cannabis, particularly at times of stress, indicating that these are still coping mechanisms for him. Mr A has also committed violent acts whilst under stress, both in the form of assaulting people and damage to property. Therefore there is potential for this to occur during stressful situations. Mr A has demonstrated he has particular problems with emotional control and that this may have been central to the assault on his partner….What should be considered however, is that these are life long behaviours for Mr A and he is likely to require a great deal of work exploring issues such as his anger control, empathy, impulsivity, and failure to accept responsibility for his actions.'

10.39 As a result of the conclusions reached at Paragraph 9.38 above, the following recommendation was made:

'Mr A may benefit from completing an established domestic violence group as well as further work exploring his anger and emotional control. Mr A may also benefit from completing work with a psychotherapist exploring some of the more entrenched behaviours that place him at risk of further violent offending. It is possible that attending counselling sessions with his partner will not fully explore the depths of his problems in relation to emotional control, empathy and stress tolerance. He would therefore be at risk of violently offending, particularly against those who are close to him at times of stress.'

10.40 Key Points

1. Mr A's history demonstrates a considerable and long-standing contact with mental health services from a relatively early age.
2. Mr A was assessed by a number of psychiatrists, none of whom took the view that he was suffering from a mental health illness. Instead, the psychiatrists who assessed Mr A were of the view that Mr A's problems were personality issues related to a background history of physical abuse and other problems. Mr A's personality issues were characterised by low self-esteem, over-sensitivity, impulsivity, difficulty in sustaining interpersonal relationships and employment, a low tolerance of stress and

poor anger control. He also had a tendency to abuse alcohol and drugs to counter his personality difficulties.

3. In September 1999, Mr A was offered residential treatment at Yeldall Manor. Yeldall Manor is a charity which provides residential rehabilitation, including detoxification to men aged between 18 and 65, with long-term drug and/or alcohol dependencies. Yeldall Manor offers a two stage programme of residential rehabilitation, which provides the framework to enable men to overcome their substance misuse issues. Mr A refused to accept the offer of a place at Yeldall Manor.
4. In March 2001, Mr A received a custodial sentence for assault and criminal damage. He was released in August 2001.
5. Mr A was regarded as violent and in December 2001 was noted to present a serious danger to the community as a result of his history.
6. In April 2002, the possibility of a referral to the Henderson Hospital, a residential unit for individuals with personality disorders, was discussed with Mr A. However, Mr A did not wish to take up a placement there.
7. On 27 May 2002, Mr A violently attacked Consultant Psychiatrist 1 at St Paul's Hospital in response to being discharged from hospital. Following this, Mr A was referred to the MAPPA process for assessment in terms of the risk which Mr A posed to the public. Guidelines were put in place in relation to his attendance with mental health services.
8. Mr A was charged with assault against Consultant Psychiatrist 1. During the resulting criminal proceedings he requested and was referred to the Henderson Hospital on 19 July 2002 by a Psychologist from Dacorum CMHT. The Independent Investigation Team has not been provided any further details regarding this referral.
9. Following the assault on Consultant Psychiatrist 1, Mr A received a custodial sentence for this and other offences. He was released in November 2003.
10. Mr A was assessed as being of MAPPA risk level 3 on 1 April 2005 in response to several incidents of violence against his partner. Her daughter was placed on the child protection register.
11. On 11 July 2005, Mr A attended Accident and Emergency with injuries including a broken arm. Media reports from Mr A's trial for the murder of the Deceased indicated that the Deceased was among those responsible for the attack on Mr A that resulted in significant injuries to him.
12. Mr A was assessed by Consultant Forensic Psychiatrist 1, a Forensic Psychiatrist, on 21 September 2005. Consultant Forensic Psychiatrist 1 did not recommend any order for Mr A under the Mental Health Act. Consultant Forensic Psychiatrist 1

recommended that Mr A be referred to the Henderson Hospital. This is a hospital which specialises in the care of individuals with personality disorders.

13. An assessment was undertaken by a Forensic Psychologist on 24 October 2005. Mr A refused to take part in this assessment. This assessment stated that Mr A had: '*moderate levels of psychopathy and indicates the presence of some psychopathic traits, although a full diagnosis may not be made. Mr A demonstrates specific concerns in the areas of poor behaviour controls; lack of remorse/guilt; irresponsibility; failure to accept responsibility for own actions; revocation of condition release; and criminal versatility. To a lesser degree he also demonstrates concern in the areas of a need for stimulation, manipulation, lack of empathy, parasitic lifestyle, early behavioural problems, impulsivity and juvenile delinquency.*

    …

    Given the scores for the PCL-R and the VRAG, there is evidence to suggest that there is a medium risk that Mr A will offend again in a violent manner. Although the tools do not differentiate between domestic and stranger violence, Mr A's history would indicate that he may be at risk of committing either.'

14. Mr A's past medical history reveals a pattern of non-attendance at appointments with mental health services. In 2002 and 2004, Mr A was discharged from care by CMHTs as a result of his non-attendance for appointments.
15. In February 2006, Consultant Psychiatrist 1 took a decision that he would remain responsible for Mr A's care due to difficulties which Mr A had in trusting people. Consultant Psychiatrist 1 was of the view that he and Mr A *'went back a long time'* and had an established relationship.

11.0 CONTACT WITH MENTAL HEALTH SERVICES IN THE PERIOD LEADING UP TO THE DEATH OF THE DECEASED

11.1 The following table outlines Mr A's contact with medical services in the period leading up to the death of the Deceased:

Date	Description of contact
02 August 2006	Report prepared by Consultant Psychiatrist 1 for Mr A's solicitors. Mr A's ongoing diagnosis was of an emotionally unstable personality disorder. Consultant Psychiatrist 1's report stated: '*Mr A is handicapped by life long personality difficulties which are understandable from his upbringing in which he was subjected to neglect and physical abuse. His personality difficulties are characterised by low self esteem, over sensitivity, impulsivity, low stress tolerance and difficulty sustaining interpersonal relationships. Mr A felt the need in the past to depend on alcohol and drugs to counter the limitations caused by his personality traits. The input by Dacorum Mental Health Services was limited to crisis intervention until September 2005 without major structural changes happening to Mr A's personal makeup and behaviour.* *Over the past year however Mr A has demonstrated admirable efforts in getting help for his substance misuse and for support in difficulties with his relationship in the past.* *…* *Mr A agreed to be assessed and followed up by Consultant Forensic Psychiatrist 1 who confirmed a positive development in Mr A's behaviour and attitude. Both Consultant Forensic Psychiatrist 1 and myself were of the opinion that Mr A was and is making a real effort to lead as normal a life as possible, taking into account his background.* *…* *In my opinion Mr A deserves credit for the steps he has taken to address the risk of him resorting to aggressive and violent behaviour. He himself requested anger management but unfortunately our trust has been unable to deliver a treatment module which would specifically address these issues*'. Consultant Psychiatrist 1 noted that Mr A had moved out of his catchment area but expressed an intention to continue to treat Mr A at St Paul's, Dacorum CMHT.
03 August 2006	Mr A was re-referred to Consultant Psychiatrist 1 by his GP following Mr A's daughter being taken into foster care. His GP raised concerns regarding the level of verbal aggression and intimidation which the GP had perceived towards staff at the GP practice, leading him to consider transferring Mr A's care to the violent patient GP unit in Luton. The GP stated: '*I would be most grateful if you could arrange to see Mr A once again, in view of this difficult development in the couple's life, to assess his mental state and also to advise him and myself about other support we can put in place for him when he perceives there to be crises so that he does not channel this in a negative way which might be to the detriment of his healthcare. I would be most grateful if you could offer an urgent appointment as I feel that his needs at present are very urgent, and he was also asking if it is possible to access behavioural therapy so that his anger management can be moderated and controlled better in the future*.'

4 August 2006	Mr A failed to attend a review appointment with Consultant Psychiatrist 1.
16 August 2006	Letter from Consultant Psychiatrist 1 to Mr A's GP regarding his assessment of Mr A on 11 August 2006. Mr A had requested that Consultant Psychiatrist 1 organise behavioural therapy. Consultant Psychiatrist 1 recommended the following action plan: *'I explained to Mr A that a referral to the psychology department at St Paul's would be a lengthy affair and that the outcome of an assessment would be uncertain. An added difficulty is the fact that he now lives in Harpenden which is outside my catchment area and that might well result in him being refused by our psychologist. The best way forward in my opinion is if you would be able to find funding so that he could access his behavioural therapy locally which evidently would help his case in court. I agreed to review him again in two months time'.*
22 August 2006	Mr A was informed that a scheduled follow up appointment with Consultant Psychiatrist 1 on 8 September 2006 had to be rearranged to 5 September 2006 due to unforeseen circumstances on the part of Consultant Psychiatrist 1.
01 September 2006	Mr A was informed that a scheduled follow up appointment with Consultant Psychiatrist 1 on 5 September 2006 had to be rearranged to 6 September 2006 due to unforeseen circumstances on the part of Consultant Psychiatrist 1.
15 September 2006	Email from CMHT Manager at St Albans to Mr A's GP, Consultant Psychologist 1 at St Albans CMHT, and Consultant Psychiatrist 1 following from a telephone conversation between Mr A's GP and St Albans CMHT. This stated: *'We have agreed that this is a very complex case and very well known to several managers within the CMHT and Consultant Psychologist 1 will liaise with Consultant Psychiatrist 1 to discuss appropriateness of a CBT assessment here at Edinburgh House given the long history and established contact with Hemel CMHT'.*
15 September 2006	Letter from St Albans CMHT to Mr A offering him an appointment with Consultant Psychologist 1 on 11 October 2006. It noted that Mr A had been referred to St Albans CMHT but does not identify who was responsible. Mr A's GP records indicated that it was Mr A's GP who made the referral.
6 October 2006	Mr A was seen by Consultant Psychiatrist 1 at St Paul's, Dacorum CMHT. Consultant Psychiatrist 1 noted that Mr A had been assessed by Consultant Psychiatrist 4 on behalf of the court who indicated that Mr A might benefit from an 18 month residential placement/treatment for behavioural modification. Mr A felt that he was not in need of such treatment at the Henderson Hospital. Consultant Psychiatrist 1 noted that the ongoing diagnosis was one of antisocial personality disorder and that he would review Mr A in three months.

11 October 2006	Mr A was seen for the first time by Consultant Psychologist 1 at St Albans CMHT. Consultant Psychologist 1's note of the consultation stated: '*Seen at request of Consultant Psychiatrist 1 and GP, as now resident in Harpenden (though temporarily moved out to brother in Hemel for legal reasons). Referral is with a view to continuing anger management work, to reinforce successful changes over past 18 months.* *…* *He presented as cooperative and motivated and gave an account suggesting that nowadays, he is not violent and on questioning, his account suggests he is not over-sensitive to put-downs from others. However, as Consultant Psychiatrist 1's correspondence suggests, he is nowadays verbally aggressive in the face of the reluctance of Children Schools & Families to allow him to live under the same roof as his six month old daughter and recent wife due to his earlier forensic history.* *…* *Specifically, he wants to learn ways of controlling his verbal behaviour and his general manner, which can be construed as menacing, when frustrated by restrictions placed upon him by CSF and is concerned to avoid misrepresenting himself at Child Protection meetings and court appearances aimed at determining child care arrangements.* *It was agreed that role-play of potentially provocative situations would be a way forward in acquiring greater control. CMHT policy requires that the intervention is short-term*.' An appointment was scheduled for two weeks' time.
19 October 2006	Letter from Consultant Psychologist 1 to Mr A's solicitors. Mr A's solicitors had written to Consultant Psychologist 1 asking for details of Mr A's treatment and described it as *'medium to long term out patient psychotherapy*'. Consultant Psychologist 1's letter stated: '*Contrary to your understanding, I have agreed to see him on a short-term basis, with a view to CBT to consolidate considerable progress regarding anger management*.'
24 October 2006	Mr A was seen by Consultant Psychologist 1. Patient Record stated: '*Seen for CBT. Role play of provocative situations, including pt being contradicted and disbelieved. Able to make statements, such as 'We'll have to agree to differ on that'. He reported that he felt some inner anger, but was able to control it well.* *...* *It was explained to him that this contact will be limited to six sessions. Initially, he was resistant, to the notion that he would have to use progress gained to cope alone, asking where else he will be referred and whether residential care would be available, but accepted the point that progress involves being able to cope without indefinite support.'*
09 November 2006	Letter from Consultant Psychiatrist 1 to Consultant Psychiatrist 3 at the Cassel Hospital regarding a potential referral. The letter stated: '*Thank you for agreeing to see Mr A in the near future for an assessment at the Cassel Hospital with a view to ascertaining his suitability for residential treatment in the therapeutic community at the Cassel. We spoke on the telephone yesterday 8th November 2006 and it is my understanding that you have also spoken to Consultant Psychiatrist 4, Consultant Psychiatrist and independent expert witness*

	for the Court, who indicated that he might benefit from intensive residential treatment. *Mr A has been diagnosed by me as suffering from a mixed personality disorder with antisocial narcissistic and borderline character traits.* *…* *Consultant Psychiatrist 4 and I both were of the opinion that Mr A would benefit from treatment at the Cassel Hospital to address the deep seated personality difficulties.* *…* *Mr A has also started a limited number of CBT sessions by Consultant Psychologist 1, Psychologist based at Edinburgh House in St. Albans. He is still seeing his Counsellor from Turning Point to help him abstain from taking substances*.'
19 November 2006	Mr A was seen by Consultant Psychologist 1. Patient Record stated: '*3rd appt of six for brief CBT for anger management.* *Has attended court several days re custody of daughter and coped well. Did not have to speak publicly.* *...* *He was praised for keeping in control, but advised to comply with requests from care staff, as a goal. He described such compliance as 'leaving with my tail between my legs' (indicating perceived humiliation and submissiveness). He was advised to develop a sense of pride and self-respect in rising above such situations, demonstrating to himself the ability to collaborate. Asked to come with examples of compliance despite his contrary feelings at next session.* *Appeared sensitive and close to tears re remorse for violent acts committed in past, including assault on Consultant Psychiatrist 1. Advised he may need to experience the discomfort of past memories as part of change process, but to attach thoughts to the effect that he has come a long way forward in terms of change. Genuine remorse in evidence.'*
20 November 2006	Letter sent from Cassel Hospital to Consultant Psychiatrist 1 confirming that Mr A had been given an appointment on 7 December 2006 with Consultant Psychiatrist 3.
07 December 2006	Report by Consultant Psychiatrist 3 on Mr A. Consultant Psychiatrist 3 noted: *'Overall, I thought that there were enough positive factors, both in the recent development and in my assessment meeting with him, to warrant inpatient treatment at the Cassel Hospital and to indicate a fair possibility of improvement through treatment. At the same time, the prognosis has to be seen with caution. There would be some risk of him not being able to use treatment or jeopardizing it through returning to alcohol and drugs or to violence.*'
11 December 2006	Mr A failed to attend appointment with Consultant Psychologist 1 due to illness.
11 December 2006	Mr A de-registered from MAPPP as reported behaviour was not causing concern.
20 December 2006	Letter from Consultant Psychiatrist 1 to Hertfordshire County Council regarding Mr A's referral to the Cassel Hospital. This letter stated: '*Would you please be so kind to consider funding authorisation for the treatment of*

	Mr A at the Cassel Hospital for the duration of one year as a residential patient. This gentleman has an extensive history as a mixed personality disorder with borderline, narcissistic and anti social character traits. Enclosed I will send you a copy of the comprehensive assessment report by Consultant Psychiatrist 3, Consultant Psychiatrist and head of the adult unit at The Cassel Hospital in Surrey. Mr A has come a long way keeping himself out of trouble, abstaining from alcohol and drugs and remaining in a stable relationship with his newly wed wife. I strongly support Consultant Psychiatrist 3's conclusion that Mr A might benefit from in-patient treatment at The Cassel Hospital which would cost the community less when offset against the risk of him relapsing into antisocial behaviour resulting in hospital admissions or a certain time in prison. I am more than happy to present his case at your earliest team meeting.'
8 January 2007	Minutes of an emergency MAPPP meeting held regarding Mr A. The meeting was called due to threats made by Mr A to a staff member of Children Schools and Families responsible for supervising contact between Mr A and his daughter. Mr A responded to an unwillingness to discuss paperwork with aggressive behaviour and threats of violence including threats to use a gun. Police were called and attended after Mr A had left. The minutes of the meeting also stated: '*Chair has spoken with Consultant Psychiatrist 1 who has been working with Mr A. Mr A has been putting in a lot of work to have contact with child. He needs specialist residential treatment and it is not clear if there is funding. He has a personality disorder. When he has taken drugs or alcohol he has become very violent and abusive. He co-operates up to a point but only likes things on his terms. He appears to have been keeping out of trouble.* *…* *Risk Management Plan:* 1. *The way forward seems to be a solid commitment to funding for specialist treatment. CSF need to push this through MH.* 2. *The [Cassel] have accepted him as patient after doing initial assessment. Next issue with them is getting funding. Reality of success is not very high.* *…* 3. *Thought that Mr A is living at mothers or brothers between Harpenden-Hemel. It would be very difficult to find out where Mr A is living.* *…* *Decision: to be re-registered on MAPPP Level 3*.' Consultant Psychiatrist 1 was passed the minutes of the meeting.
9 January 2007	Letter sent from Hertfordshire Joint Commissioning Team to Consultant Psychiatrist 1 informing him that funding was not available for a residential placement at the Cassel due to the lack of a service arrangement with them. They recommended that Consultant Psychiatrist 1 should either obtain exceptional funding from the PCT or should make a referral to the Henderson Hospital.
12 January 2007	Fax from Consultant Psychiatrist 1 to Mr A's GP. This stated that Mr A's GP should request exceptional treatment funding from the PCT.
16 January 2007	Letter sent from Consultant Psychiatrist 1 to Mr A. This offered him an appointment with Consultant Psychiatrist 1 on 20 February 2007.
19 January 2007	Letter sent from Consultant Psychiatrist 1 to Mr A changing the time of his appointment on 20 February 2007. No reason was given for the change.
22 January 2007	Letter sent from Consultant Psychologist 1 to Mr A cancelling an appointment and

	giving him an alternative date of 31 January 2007. No reason was given for the change.
31 January 2007	Letter sent from Consultant Psychologist 1 to Mr A. Mr A had failed to attend an appointment on 31 January 2007, apparently due to confusion regarding the appointment time. The letter apologised for the confusion and offered a replacement appointment on 14 February 2007. No further details were provided.
14 February 2007	Mr A was seen by Consultant Psychologist 1. Patient Record stated: '*Feels he has been well-controlled in the face of court accusations stemming from incident 18 months ago. Charges dismissed. Also, says has had some difficult moments with CSF without losing temper. 'I'm looking for prevention now'. Proud of his progress. Reflected that his difficult early childhood cannot be changed by that his temperament can.* *Necessity of a year's attendance at a therapeutic community may not be necessary, but currently, he says CSF are insistent upon such a placement. Encouraged to discuss with Consultant Psychiatrist 1.* *Has been offered a job as a house extension salesman for Anglican, which he is unsure whether to accept because of the possible therapeutic community placement*.'
13 March 2007	Mr A failed to attend appointment with Consultant Psychologist 1. Consultant Psychologist 1 noted that no immediate action would be taken. Consultant Psychiatrist 1 notified.
16 March 2007	Letter sent from Consultant Psychiatrist 1 to Mr A offering him an appointment on 27 March 2007.
27 March 2007	Letter sent from Consultant Psychiatrist 1 to Mr A's GP. This letter stated: '*Mr A had an outpatient appointment with me today Tuesday 27 March 2007. He did not attend nor did I hear from him. He has now missed three consecutive outpatient appointments and, therefore, I have no other option but to discharge him from my caseload and transfer his care back to you.* *It is my understanding that the referral to the Cassel Hospital for further treatment will not be funded by the PCT…* *He has now moved out of the Dacorum area and I would suggest to you that if in the future Mr A is in need of psychiatric services that he should be referred to the St Albans CMHT. I have not been able to formally write to Mr A about my decision to transfer his care back to his GP because I have not got his Harpenden address. Please feel free to share the content of this letter with him when he comes to your attention*'.
26 April 2007	Letter sent from Director of Public Health at HPFT to Mr A's solicitors explaining that although the PCT could not fund the referral to The Cassel, they would fund a referral to The Henderson Hospital with whom they had a service level agreement. However, such a referral would need to be made by a consultant psychiatrist. As Consultant Psychiatrist 1 had discharged Mr A, he would not be in a position to make such a referral.
21 May 2007	Letter from Mr A's solicitor to Consultant Psychiatrist 1 informing him that the PCT were prepared to fund treatment at the Henderson and that Mr A agreed to such treatment. The letter stated:

	'*We believe that a formal referral will need to be made to the Henderson and wonder whether you would be in a position to make such a referral notwithstanding that you have discharged him back to the care of his GP. We are informed by the Henderson that their system for referral and assessment is dependent on pre-approved funding (which we appear to now have) and a referral from a psychiatrist. They do not accept referrals from GPs.'*
22 May 2007	Referral from Consultant Psychiatrist 1 to the Henderson Hospital. The referral stated: *'Mr A has been diagnosed by me as suffering from a mixed personality disorder with antisocial narcissistic and borderline character traits.* *…* *I was called to testify at the High Court in London in November 2006 in the case of Social Services in St Albans expressing their grave concern regarding Mr A's parenting skills and potential to violent behaviour. Consultant Psychiatrist 4, Consultant Psychiatrist and independent expert Witness for the Court, and I were both of the opinion that Mr A would benefit from treatment at the Henderson Hospital to address the deep seated personality difficulties.* *…* *He has also started a limited number of CBT sessions by Consultant Psychologist 1, Psychologist, based at Edinburgh House in St Albans. He is still seeing his Counsellor from Turning Point to help him abstain from taking substances.* *Enclosed I will send you a copy of a report by Consultant Psychiatrist 3 from the Cassel Hospital. Unfortunately, the PCT were not in a position to fund treatment at the Cassel but they have a contract with the Henderson and would authorise payment for treatment at your institute'.*
30 May 2007	Mr A contacted Consultant Psychologist 1 seeking an appointment. Consultant Psychologist 1 noted that he had not formally discharged Mr A and agreed an appointment on 4 June 2007.
30 May 2007	Letter sent from HPFT to Mr A's solicitors. Letter stated: *'As per our letter of 26 April 2007, we confirm that the PCT will support funding of Mr A's referral to the Henderson Hospital.'*
30 May 2007	Letter sent from Henderson Hospital to Consultant Psychiatrist 1 regarding referral. Letter stated: '*Thank you for referring Mr A for assessment by ourselves. In order to proceed could we please ask you for further information.* *Please find enclosed a referral information form and CMHT form. Could we please also have copies of CPA and risk assessment information if this is available. Once we have received this information, we can forward the referral on for funding application*.'
4 June 2007	Mr A attended final appointment with Consultant Psychologist 1. Mr A was discharged following this appointment. Patient Record stated: '*Seen for last session, specifically for anger management in handling frustrating situation re appealing for access to 13 month old child. Has coped reasonably well, according to pt, with no major incidents. Given forensic history, has been relatively*

	free of trouble with the law and feels he has contained himself and avoided explosive incidents with CS&F. However, has split from girlfriend, who he says moved to a refuge in Cambridge on instruction of Social Services. They might be getting back together again. *Reported recent interview with CS&F social worker in which he claims he stood in front of her car to prevent her driving away with partner and child in a car with defective front tyres and claims his foot was run over by car wheel in process. Police now involved at pt's request.* *Discharged today, discharge letter to Consultant Psychiatrist 1 to follow.'*
06 June 2007	Short report from Consultant Psychologist 1 at the request of Mr A's solicitors. The report stated: *'Thank you for your request for an urgent short report on the above 36 year old, who has an emotionally unstable personality disorder. I have seen him at the request of Consultant Psychiatrist 1, the Consultant Psychiatrist treating the patient at the time, and at the request of the patient's GP.* *He was seen on six occasions, with a view to cognitive behaviour therapy (CBT) for anger management. He has a forensic history, including poor impulse control and violence, exacerbated by substance abuse. To his credit, he has refrained from ingestion of illegal substances and made many positive steps prior to me seeing him…my impression is that this progress has been maintained.* *…* *He has been motivated and co-operative in sessions. Attendance is likely to have been of some benefit in consolidating progress initially achieved by Consultant Psychiatrist 1. There is no further likely benefit above and beyond the input already provided. Therefore contrary to the patient's account that my involvement with him is likely to be ongoing, he has now been discharged from the Psychology Department and I do not plan to continue contact, as explained to him at the time.'*
06 June 2007	Letter from Consultant Psychiatrist 1 to Consultant Psychiatrist 2, Consultant Psychiatrist at St Albans CMHT. The letter stated: '*Thank you for taking over the care of Mr A who is well known to the St Albans CMHT Manager and Consultant Psychologist 1 diagnosed with a dissocial personality disorder. He has been under my care for many years with a modest degree of treatment outcome.* *…* *Mr A has been living with his mother in Harpenden for the past 6 month, formally being of no fixed abode. He is registered with a GP in Harpenden and I told Mr A that I would transfer his care to you now he has moved out of my catchment area.* *…* *Sorry this is all a bit messy but in a sense it reflects the nature and degree of Mr A's involvement with the mental health services*.'
07 June 2007	Letter from Consultant Psychiatrist 1 informing Mr A's solicitor that care had been *'formally transferred'* to Consultant Psychiatrist 2.
08 June 2007	Email from St Albans CMHT Manager to Consultant Psychiatrist 1. Email stated: *'I was very surprised to learn today that Consultant Psychiatrist 2 has been put as care co-ordinator and consultant without an appropriate CPA handover. I have*

	therefore removed Consultant Psychiatrist 2's name until a handover is agreed as per policy. *I remember discussing with you briefly in passing some time ago that you were making a referral to the Henderson. Given the violent history and high profile (MAPPP level 3) nature of Mr A's case it would be more appropriate and good practice that you (who knows him best) signs the referral with the Hemel CMHT signing the agreement to receive care back once he is discharged. If Mr A on discharge from the Henderson chooses to live in Harpenden with his mother then a CPA handover and transfer of care can be appropriately made with the St Albans CMHT*.'
11 June 2007	Email from Consultant Psychologist 1 to Consultant Psychiatrist 1. Email stated: '*Just to let you know that I discharged Mr A last week and sent short legal report on Carenotes, in case you are asked to provide a statement or report yourself*'.
14 June 2007	Death of the Deceased. Mr A taken into custody.

11.2 During this period, the following report was also prepared relating to Mr A's issues:

11.3 Assessment Report for Inpatient Treatment (The Cassel Hospital), 7 December 2006

11.4 Mr A was referred to The Cassel Hospital by Consultant Psychiatrist 1 at the Dacorum CMHT, in conjunction with Consultant Psychiatrist 4, a Consultant Psychiatrist at St Georges in South London who was acting as expert witness in relation to court proceedings involving Mr A. Social services had expressed grave concern regarding Mr A's parenting skills and potential for violent behaviour. Consultant Psychiatrist 1 and Consultant Psychiatrist 4 were both of the opinion that Mr A might benefit from treatment at The Cassel Hospital, a specialist residential unit for the treatment of severe personality disorders. He was assessed by Consultant Psychiatrist 3, a Consultant Psychiatrist practising at the Cassel Hospital.

11.5 In relation to Mr A's background, Consultant Psychiatrist 3 noted in the referral letter that Mr A was described as:

> *'suffering from a mixed personality disorder with anti-social, narcissistic and borderline character traits. He suffered from neglect and abuse as a child, growing up in a Traveller's family where standing out aggressively was seen as a way to express one's assertiveness. He has had 'many brushes with the law' fuelled by excessive alcohol and illicit drug use. He has been under the care of Consultant Psychiatrist 1 for the past five years who describes the therapeutic relationship as "rocky from the start, to say the least." However, Consultant*

Psychiatrist 1 writes that Mr A "has made some remarkable steps in the right direction by engaging with anger management training and drug and alcohol services. He is more or less abstaining from cannabis misuse and alcohol and has kept out of prison for the past two years." '

11.6 Consultant Psychiatrist 3 stated:

'Consultant Psychiatrist 4 indicates that "Mr A's underlying personality problems are entrenched and life-long. Even with the benefit of the extensive psychotherapy he has not had, he is likely to continue to exhibit features of emotionally unstable personality disorder, especially at times of crisis." Consultant Psychiatrist 4 got the strong impression on meeting Mr A that he is on the road to a deeper level of understanding but does not think that he has got all the way there yet.

The summary of the assessment at Jamma Umoja Family Centre indicates that they were going to carry out a 12 weeks residential assessment but that Mr A's assessment was terminated after 10 weeks, end of July 2006. According to the report Mr A "expressed his anger and anxiety to staff in a manner which they often considered to be out of proportion to the concern involved. He was described as dominating and intimidating. He accepts himself that his behaviour was rude, discourteous and unacceptable on occasions and that he regularly used abusive and foul language and would shout and become agitated." '

'In a further report of 8th September 2006, Consultant Psychiatrist 4 writes that the fresh evidence does not change his views and in fact re-enforces his opinion of Mr A's personality problems. On the basis of the report from Jamma Umoja he sees an "immediate risk of exposure to aggression between Mr A and others" but no real risk that Mr A would pose a direct physical threat to his daughter. Consultant Psychiatrist 4 expresses his doubts about Mr A's capacity to make the necessary degree of change at the present time, if indeed ever, but indicates that the "shortest route to a successful outcome" would be residential psychotherapy in a therapeutic community specialising in the treatment of people with personality disorders, such as The Henderson or The Cassel Hospital.'

11.7 In relation to his assessment at the interview, Consultant Psychiatrist 3 reported:

'He came across as very driven, with only a limited capacity to listen and remain silent, or to calm himself down. His speech was very pressured and he would often talk over me or interrupt me, requiring quite forceful interventions from me to stop him and make him listen, which was sometimes, but not always, successful. He did not come across as particularly aggressive and at no point in the meeting did I feel under threat of violence, even when I challenged him quite strongly. His mood appeared partly anxious and partly euphoric.'

'At the beginning he gave an overview of his life which placed great emphasis on the collapse of his father's business as a cause of his getting into trouble,

including alcohol and drugs. He told me about the enormous impact it had on him when he read the files that Social Services had on him about his childhood. He initially thought that happened in 2003, but then thought in 2005 after he had been released from prison. Up until then, there had been suspicions that he had been sexually abused by his father, which had made him full of anger and violence. Reading his files and finding out that he had not been sexually abused was an enormous relief to him. He felt it was then things turned around in him and he wanted to change his life and get help for it. He spoke as if the suspicion of sexual abuse had been the cause of his behaving violently much of his life. However, it emerged that this suspicion had been written into a document only a few years before, in 2000 or 2001. At the time this had affected him so much that he attempted suicide. Since he read the files, however, he has changed enormously, he hasn't been violent and he has not used drugs or alcohol.'

11.8 When exploring in interview what Mr A thought his problems were, Consultant Psychiatrist 3 noted that:

'He clearly found this difficult to think about, and was very vague, even when I tried to pin him down a bit more. He did say, however, that he often came across as aggressive or threatening, but the way he put it, it seemed to be more a matter of behaviour than what was going on in inside him [sic]. I tried to explore how he felt, and whether he often felt very aggressive or even violent. He said that the way I was challenging him (and I was deliberately quite forceful) would have made him feel very angry, and he would have run off in the past, whereas he was now able to stay; however, he was not able to speak about the feelings this might evoke in him now. In a very general way, he also spoke about wanting to be able to lead a normal life, but could not describe in what way his life was not normal now, apart from the external factors of Social Services, the Court and separation from his wife and child.'

11.9 In relation to illicit substance and alcohol intake, Consultant Psychiatrist 3 noted:

'He was introduced to alcohol and drugs around the age of 14, initially, for example, at family events, but said (in contrast to some of the reports) that he only got into heavy drinking and drug-taking at the age of 18. He told me that he had not drunk alcohol or taken cannabis in the last two years, but when I challenged him about that, knowing that this was incorrect, he admitted that he had been drinking and using cannabis much less than in the past and had only stopped completely about 10 weeks ago. I also heard from him about his criminal history, thieving, burglary and violence, for which he went to prison several times. Although he described this as a kind of bad history which he had got over, I felt I sensed a certain pride in his capacity to be such a criminal, or to drink and take drugs to the extent that he did. When I confronted him with that, he reacted evasively, but seemed to admit it to some degree.'

11.10 In relation to instances of violence, Consultant Psychiatrist 3 noted that:

'He also told me about what led up to the most recent of his prison sentences, for five months in 2004/2005. There was a violent row between him and his partner while they were both completely drunk. He presented it as if it was equal from both sides, and I challenged him on that, after all he had gone to prison for it. He said that obviously he was much stronger and a 'big bloke' (and he stood up in front of me, showing how big he was, although not in a way that felt threatening). This meant that he really injured her and he was sentenced to Grievous Bodily Harm.'

11.11 Consultant Psychiatrist 3 concluded by saying:

'Mr A is a very disturbed man with a mixed personality disorder with borderline, antisocial and narcissistic traits. His personality disorder appears to have developed as a consequence of neglect and abuse as a child, the details of which, however, I do not know. He has developed a serious tendency for violence, both in his relationship to his partner and towards others, increased particularly by his extensive misuse of alcohol and drugs. In response to various factors in the recent past, including his partner reporting the domestic violence to the police and him going to prison for that, his access to Social Services files and a positive development between him and his partner, he has become motivated to change the course of his life. Subsequently he has made significant steps, for example reducing and apparently now stopping completely, his use of alcohol and drugs. He also sought help such as anger management and, in conjunction with the reduction in alcohol and drugs, this has helped him refrain from direct violence.

The recent development gives positive indicators for the capacity to use treatment and change. These were supported also by the motivation he expressed in the assessment and his capacity to tolerate tough challenging by me. However, there are also other factors that cast doubts on his capacity to change. His motivation for treatment seems, to a good degree, driven by his wish to be re-united with his wife and child, while his insight for his own personality problems is more limited. He obviously wanted to give me a very good impression, knowing how much might depend on the assessment; he therefore may have actively underplayed his more aggressive and intimidating behaviour. While he easily blamed others as failing (such as social Services and the Family Assessment Centre), he found it much more difficult to look at his own behaviour and experience.

Overall, I thought that there were enough positive factors, both in recent development and in my assessment meeting with him, to warrant inpatient treatment at The Cassel Hospital and to indicate a fair possibility of improvement through treatment. At the same time, the prognosis has to be seen with caution. There would be some risk of him not being able to use treatment or jeopardizing it through returning to alcohol and drugs or to violence.'

11.12 Key Points

1. Mr A continued to experience difficulties due to his long standing personality issues.
2. In August 2006, Mr A was living in Harpenden outside the catchment area of Dacorum CMHT. At this time, Mr A was advised by his GP that he would be transferred to the violent patient unit in relation to his primary care as a result of threats Mr A made to practice staff if he did not moderate his behaviour.
3. On 16 August 2006, Mr A asked that behavioural therapy be made available to him. Consultant Psychiatrist 1 advised him that due to Mr A living outside the Dacorum catchment area Mr A could not access such services through the Dacorum CMHT easily. However, Consultant Psychiatrist 1 recommended to Mr A's GP that funding be obtained to enable Mr A to access behavioural therapy from the St Albans CMHT instead.
4. On 15 September 2006, it was agreed that Consultant Psychologist 1 at St Albans CMHT would liaise with Consultant Psychiatrist 1 from Dacorum CMHT regarding arranging a CBT assessment at St Albans CMHT. No referral documentation exists evidencing the rationale for Consultant Psychiatrist 1's referral to Consultant Psychologist 1. Mr A's first appointment with Consultant Psychologist 1 was on 11 October 2006.
5. During November 2006 Consultant Psychiatrist 1 arranged for Mr A to be seen at the Cassel Hospital with a view to ascertaining his suitability for residential treatment in the Cassel Therapeutic Community. The Cassel Hospital provides national specialist assessment and treatment services for adults, young people and families with intractable personality and family problems. The ESPD Service (Emerging and Severe Personality Disorders) and the Families Service both provide care packages with residential, day and outreach services.
6. The Cassel Hospital confirmed that Mr A could benefit from inpatient care on 7 December 2006. The diagnosis of Mr A given by the Cassel Hospital was mixed personality disorder with borderline, antisocial and narcissistic traits. A serious tendency for violence, both in his relationships with his partners and others, was highlighted, as was Mr A's extensive use of alcohol and drugs.
7. Consultant Psychiatrist 1 took active steps to secure funding for Mr A's referral to the Cassel Hospital and wrote a number of letters on behalf of Mr A in an attempt to secure care on his behalf. This demonstrates an element of good practice on the part of Consultant Psychiatrist 1.

8. On 8 January 2007, an emergency MAPPA meeting was convened to discuss threats made by Mr A to a member of a social services team responsible for supervising Mr A's contact with his daughter. As a result Mr A was registered at MAPPA Level 3.
9. Funding for referral to the Cassel Hospital for Mr A was denied on 9 January 2007 due to HPFT not having a service provision agreement with the Cassel Hospital. Referral to the Henderson Hospital in place of the Cassel Hospital was proposed by the Commissioners. The Henderson Hospital was a residential Therapeutic Community and Outreach service offering treatment to individuals diagnosed with a personality disorder. Mr A had previously been referred to this hospital in October 2006 but he had declined treatment at that time.
10. Appointments for Mr A to see Consultant Psychiatrist 1 were sent on 16 January 2007 and 16 March 2007. Mr A failed to attend these appointments. In addition, Mr A failed to attend a further appointment on 13 March 2007 with Consultant Psychologist 1.
11. Mr A underwent a series of appointments with Consultant Psychologist 1 for the purpose of providing CBT. This was agreed at the outset to be time-limited.
12. Consultant Psychiatrist 1 wrote to Mr A's GP discharging him from his care as a result of Mr A having missed 3 appointments. Consultant Psychiatrist 1 suggested that Mr A's future care should be dealt with by St Albans CMHT as Mr A had moved out of the Dacorum area some time previously.
13. Notwithstanding the fact that he had discharged Mr A, Consultant Psychiatrist 1 then referred Mr A to the Henderson Hospital on 22 May 2007, at the request of Mr A's solicitors.
14. Consultant Psychologist 1 discharged Mr A on 4 June 2007.
15. On 6 June 2007, Consultant Psychiatrist 1 wrote to Consultant Psychiatrist 2 at St Albans CMHT purportedly transferring Mr A's care to St Albans CMHT.
16. Mr A stabbed the Deceased on the evening of 13 June 2007.

12.0 MR A'S OFFENDING HISTORY

12.1 Mr A had a substantial forensic history prior to his conviction for murder on 15 April 2008. His first conviction was 30 August 1984 when he was 13.

12.2 By 10 January 2006 he had been convicted on 29 occasions for a total of 66 offences. These included:

Date of Offence	Details
September 1985.	Taking without authority, driving while disqualified and failure to report an accident.
1986	Obstruction resulting in a fine.
January 1987	Threatening or abusive words or behaviour. Conviction occasioning a fine.
June 1991	Driving whilst disqualified, driving without insurance, two counts of failure to provide a specimen, and a minor road traffic offence
February 1997	Affray conviction, occasioning a 6 month prison sentence concurrently with a property damage conviction.
February 2008	Possession of a CS gas or pepper spray canister occasioning a 2 month sentence consecutive to other offences.
September 1999	Failure to provide a specimen, driving without insurance, driving otherwise than in accordance with a licence, failure to give name and address and taking without consent.
March 2001	Drunk and disorderly conviction occasioning 1 days' detention.
April 2001	Assault occasioning ABH, occasioning 6 months imprisonment concurrent to other ongoing matters. Mr A pled guilty to this assault on the specific basis that he was provoked by the victim, a taxi driver,

	apparently striking his dog and that both parties had attempted to strike one another prior to the blow that caused the injury.
June 2001	Perverting the course of justice resulting in a 1 month YOI sentence consecutive to other charges.
July 2002.	Driving whilst disqualified and driving without insurance
September 2002	Two counts of assault, each occasioning 2 months imprisonment served consecutively.
November 2002	Two counts of affray resulting in 18 months imprisonment concurrent with other offences.
March 2004	Battery resulting in a 24 month Community Rehabilitation Order.
March 2004	Assault on a police officer occasioning a 24 month Community Rehabilitation Order that included both anger management and alcohol addiction courses.
June 2004	Perverting the course of justice resulting in a 4 week prison sentence.
August 2004	Driving with excess alcohol, driving otherwise than in accordance with a licence, and using a vehicle while uninsured.
March 2005	Assault occasioning ABH against his partner occasioning a 12 month Community Rehabilitation Order, subsequently varied to a conditional discharge in October 2005. NB two further allegations were raised subsequent to this of assault against his partner but were not proceeded with.

12.3 Mr A has received a variety of sentencing options including a number of custodial sentences. Following conviction for assault on a police officer on 18 March 2004 he was subject to a two year community rehabilitation order which required him to attend anger management and alcohol dependency courses.

12.4 In passing sentence upon Mr A in respect of the murder of the Deceased, the Judge made the following comments in respect of Mr A's history of violent offending:

> '*The starting point I adopt for the minimum term to be served will be 15 years. The only mitigating feature I can see is the apparent lack of premeditation. This case is aggravated by your extensive criminal record and background which includes violent offending, and by the fact that this brutal attack took place in the Deceased's own flat which it seems he had invited you to*.'

12.5 Key Points

1. Mr A had an extensive offending history. He had been convicted of a substantial number of offences including violent assaults.
2. Mr A had been given a range of different sentences including custodial sentences.

13.0 MEDICAL AND RISK MANAGEMENT HISTORY FOLLOWING HOMICIDE

13.1 The table below describes Mr A's medical and risk management history following his arrest for the murder of the Deceased and his subsequent imprisonment.

Event Date	Details of event
25 June 2007	Entry in Mr A's Patient Record. '*Prisoner seen doctor in previous few months: Yes – personality disorder {mulity sub type border narcistic triats} [sic]* *Prisoner has concerns over their physical health: Yes – anxiety and panic attack.* *Requires a course of hepatitis B.* *Prisoner receiving prescribed medication: Yes – diazepam 4mg, tamezepam[sic] 20mg, zopiclone 7.5'* *'Urine test possible of benzos and cocaine, first night carbamazepine 100mg given as he takes 5mg diazepam tds. For doctor in the morning'.*
10 July 2007	Entry in Mr A's Patient Record. '*Conclusion of the interview was that Mr A in[sic] unhappy with his current benzodiazepine detox – believes it is too rapid and is requesting to speak with the detox team to arrange a more gradual reduction. ...Believes he should be transferred, under Section 37 of the MHA, to the Henderson Therapeutic Hospital in London to address his personality disorder and is currently pursuing this with his barrister*'.
13 July 2007	Entry in Mr A's Patient Record. '*Requesting maintenance diazepam. Syas[sic] has borderline personality disorder and needs valium for this. Explained personality disorder is not a mental illness and not an indication for diazepam treatment. For another two weeks of nitol as compromise*.'
14 August 2007	Negative Voluntary Drug Test.
14 August 2007	Entry in Mr A's Patient Record. '*History: c/o insomnia, aggressively demanding something more than sominex or nitol. Heated discussion. d/w psychys. Mild tinea pedis. Adv re this clotirmazole powder*.'
22 August 2007	Entry in Mr A's Patient Record. '*Would like to see a psychiatrist to request medication to aid him to sleep. Very forceful, loud and intimidating. Informed that he will be put on the waiting list, but it is not possible to tell when he will be seen. Also wants to join relaxation group. Advised to put in an application*'.
25 September 2007	Entry in Mr A's CARAT notes. '*On arrival at HMP Bedford Mr A referred himself to the CARAT team. He*

	has now completed the Short Duration Programme, a four week CBT/Harm Minimisation programme and is regularly attending AA meetings. Referrals have been made for an Assertiveness and Decision Making course and one to improve Parenting Skills. We will be pleased to supply further details, if required.'
11 January 2008	Entry in Mr A's Patient Record. '*C/o on murder charge, father having triple bypass, not sleeping and feeling very depressed to the extent of contemplating suicide. Acct doc opened by officer. Acct doc explained to Mr A by myself and officer. To see MO as emergency appointment Saturday 12/11/08[sic]*'
14 January 2008	Entry in Mr A's Patient Record. '*pt very anxious and stressed at current situation* *pt has varies problems both personel and in the family* *Does not want citalopram or zispin* *Placed on psych list for this week* *started on increasing dose of seroquel, after advice from cpn team*'
22 January 2008	Entry in Mr A's Patient Record. '*Keen to obtain therapies stipulated by court to gain access to children. At present coping with being in custody without self harm, aggression, antiauthority behaviour. Makes use of support available on the wings. Willing to seek CPN contact if needed*.'
29 February 2008	Mr A was seen having made several superficial cuts to his left arm with a razor blade and that these were cleaned and dressed.
06 June 2008	Letter from CARAT worker. The letter stated that Mr A completed both the Short Duration Programme (SDP) for drug-related problems and a parenting course through Ormiston Children & Families Trust. Mr Stewart also noted: '*Over a long period of time as Mr A was placed on an open ACCT Document (suicide watch) as his trial date approached and after the birth of his second child. During this difficult time I visited Mr A on a weekly basis and when passing the wing he was accommodated on. At some points Mr A was quite low and referrals were placed to the mental health team to help motivate Mr A* *Mr A evidenced a lot of motivation whilst at HMP Bedford and was prompt for all appointments*'.
08 June 2008	A letter from Mr A's personal officer at HMP Woodhill. The letter stated: '*I have been a personal officer to Mr A since the 01.05.08 and in that time my overall analysis of his behaviour and conduct is a good one. Mr A has encountered a handful of issues such as property, resettlement and healthcare problems; he has always approached officers in a respectful manner and has been given the help he has needed with the above.'* He also wrote: '*Mr A has also been engaged with the a.c.c.t. whilst in custody, this is put in place to assist and help him cope whilst in prison. Some prisoners prove difficult when in this position whereas Mr A has dealt with his situation well and realises that staff have made appropriate decisions to help and work*

	with him.'
26 June 2008 - 03 December 2008	10 Negative Voluntary Drug Tests.
16 December 2008	Letter from Prison Officer to Mr A's legal team. The letter stated that Mr A had passed six voluntary drug tests since 17/05/08, had achieved Enhanced status, had been employed as a unit servery worker and had maintained a good relationship with staff and other prisoners.
16 December 2008	Letter from Prison Officer confirming that: '*has made a tremendous effort in all he has done, he has achieved Enhanced status and has maintained a high standard of behaviour. Mr A should be proud of his achievements*'.
03 January 2009	An entry in Mr A's Patient record stated that Mr A had a history of self-harming at times of stress while on remand but that he had not had further thoughts since February 2008.
14 January 2009 – 02 April 2009	4 Negative Voluntary Drug Tests.
18 March 2009	Mr A referred to mental health team at HMP Woodhill. No reason was entered in his Patient Record as to the reason why.
08 June 2009	Entry in Mr A's Patient Record. Note stated that Mr A was stressed and anxious due to ongoing problems with social services and access to his children. Mr A referred to a mental health nurse for mental health review.
08 June 2009	Mr A's records include the following: '*Mr A had been assessed previously but with current issues there is a need for a review. In 2006 he was given the diagnosis of Personality Disorder. His behavioural pattern since arriving at HMP Gartree has not given any symptoms in relation to this given his current events which are discipline related he is showing a remarkable restraint in the actions open to him. Past history would indicate a more direct violent approach however this is not what Mr A is choosing to act on. There are underlying issues that Mr A needs to tackle in order for him to continue in this process of 'reasoning'. Due to this interview will make a plan of action for future treatment programme*'. Mr A was referred to a psychiatrist for a review of his diagnosis.
21 July 2009	Mr A was given a forensic psychiatry review. His Patient Record stated: '*In recent years he has dedicated himself to changing his situation in order to demonstrate that it would be safe and appropriate for him to have access to his children. To this end, he has applied himself to a range of courses and has managed his behaviour and presentation in prison such that he has been free from adjudications and has a folder containing many recommendations, positive reports, accolades and certificates from a range of prison officers, course organisers, examiners and others. This is clearly to his credit, given his difficult childhood and the problems he was having prior to his time in custody. It is also in marked contrast to his previous*

	times in custody. *Mr A was keen for his diagnosis to be brought up to date today, and for recognition to be given to the significant progress he has made.* *At the moment, although he does have ongoing personality difficulties, he has been able, through sustained hard work, to overcome these in the prison setting. The exact nature of his difficulties is open to debate but further assessment is not required at present, in my opinion, as he is doing so well in every area of prison life.* *Mr A recognises that the difficult elements of his personality will be with him for the rest of his life, and that he will have to continue to work to manage these. He has done remarkably well with this in recent years.* *I have told him today that there is no indication for further contact with myself, as he is managing his situation so well at present. He does not require treatment in hospital and, in my opinion, does not warrant treatment in a therapeutic community at present.'*
24 November 2009	Drug Treatment and Progress Report noted that Mr A completed the Substance Treatment and Offending (STOP) Programme on 24 November 2009. Mr A was set the following objectives: *'For Mr A to identify his Negative Emotions and strategies to deal with them.* *To identify strategies to deal with boredom that does not include substances.* *For Mr A to explore Problem Solving and how he is going to relate this to solving problems in the future.* *For Mr A to look at his Thinking Errors and look at the ways to challenge him.* *For Mr A to look at High Risk Situations and to develop strategies to deal with them in the future.*' Mr A agreed to these objectives. The report stated that, while Mr A at times did not co-operate entirely with the programme, when challenged on such behaviour altered his attitude in future sessions. Mr A was agreed to have achieved his objectives through the course. It concluded that Mr A required few post-programme objectives and had demonstrated a good understanding of the programme material.
18 June 2010	Memorandum from the Thinking Skills Programme (TSP). The purpose of the TSP is to help individuals develop in three key areas of thinking and emotional self-management, specifically Self-Control, Problem Solving and Positive Relationships. The memorandum noted that Mr A had successfully completed the TSP objectives set to him. These were: *'To explore 6 problems or decisions using the problem solving strategy.* *To develop perspective taking in relation to red and green flag people.* *To consider 'red flags' and the importance of being aware of these.* *To reflect on times when you do not get what you want.'* Mr A was agreed to have achieved his objectives and was commended specifically on his progress in perspective and challenging rigid/negative thinking.
16 October 2010	Made by Prison Officer at HMP Gartree: '*During Mr A's time at Woodhill he was always polite and civil, however he*

	was a drain on staff and a difficult prisoner in the fact that whatever wrongdoings were going on i.e. drugs, alchahol[sic] etc Mr A was always involved, he had little respect for rules and procedures and behaved in a selfish and immature manner. When Mr A arrived at Gartree I expected to be dealing with the same issues as before, I could not believe the change in an individual.' *'In conclusion sir the Mr A I knew at Woodhill is a totally different man to the person I know now, he has matured and is trying to turn his life around, and is to date successful, all credit to him it has not been easy*'.
21 January 2011	Letter from Chaplain at HMP Gartree in support of Mr A's application to vary a court order in relation to his children. The Chaplain specifically noted: '*It is my opinion, based on a considerable number of meetings over the past two years, that Mr A has worked successfully to reduce some of his marked personality traits: over-sensitivity: impulsivity, low tolerance of stress, a liability to ill-tempered outbursts of anger, and a tendency to become disproportionately despondent. He now accepts the things which he cannot change, but continues to strive to press ahead, in a reasonable manner, with those things which he perceives as either wrong or unfair*.'

13.2 Key Points

1. Mr A maintained contact with mental health services upon incarceration.
2. Mr A presented to prison mental health services testing positive for benzodiazepines and cocaine.
3. Mr A engaged with the Voluntary Drug Testing routine at HMP Bedford where he was initially placed following the death of the Deceased. To date he has tested negative for all banned substances on all 15 occasions when tested.
4. Mr A obtained Enhanced Prisoner status on 9 September 2008.
5. Mr A has obtained a significant number of qualifications whilst in prison. He has undergone a number of courses to address some of his personality difficulties.
6. Reports from prison officers and practitioners involved in Mr A's care have been positive in relation to his co-operation with services and his personal development.

14.0 AVAILABILITY OF SERVICES TO MR A

14.1 Personality Disorder

14.2 Mr A was diagnosed at different points during his contact with mental health services with antisocial personality disorder and emotionally unstable personality disorder. This was the ongoing rationale for his treatment.

14.3 Individuals with personality disorders often face discrimination within a healthcare setting. Pervasive attitudes among clinicians, health care administrators and policy makers perpetuate the marginalisation of people with personality disorders within systems of mental health care. Patients with a personality disorder may not be regarded as suffering from a 'legitimate' illness by some and accordingly viewed as a drain on resources (a view not held by the Independent Investigation Team). Lack of suitable mental health services may be rationalised based on these attitudes. Similar difficulties occur for individuals who present with substance misuse problems in terms of access to health care.

14.4 However, personality disorders are common. Epidemiological estimates suggest that between 5% and 13% of people living in the community have problems that would meet the diagnostic criteria for personality disorder. Coid, J., Yang, M. et al (2006); Moran, P. (2002). It is also believed to be highly prevalent within the prison population, with between 64% and 78% of adult male prisoners meeting the diagnostic criteria.

14.5 People with personality disorder often present with a range of physical, mental health and social problems such as substance misuse, depression and suicide risk, housing problems and long-standing interpersonal problems. Epidemiological studies indicate that 20-50% of people with personality disorder misuse substances and 5-30% of people who attend substance misuse services have a diagnosis of personality disorder. Linehan, M., Schmidt, H. et al (1999); Nace, E., Davis, C. and Gaspari, J. (1991).

14.6 Personality disorders are associated with risk. Risk of suicide and accidental death is high and it is estimated that between 47% and 77% of people who commit suicide have personality disorder. Moran, P. (2002); Alwin, N., Blackburn, R. et al (2006).

14.7 Because some people with personality disorder engage in impulsive or dangerous lifestyles, they have a higher risk of unnatural or accidental death. A small sub-group may present a high risk to others due to their violent or sexual offending.

14.8 People with personality disorder often have a complex range of problems and needs, and they may be involved with a number of different agencies. However, their personality disorder may affect their ability to benefit from services. Without the right kind of help and support, their problems are likely to persist.

14.9 The Operational Policy adopted by Dacorum CMHT includes the following in its eligibility criteria:

'7. Eligibility for services.

6.1 Decisions on whether someone should be accepted for services should always be based on their health and social care needs as a whole and not on diagnosis alone. However following an assessment of need, priority for services will be given as shown in sections 6.1 – 6.9.

6.2 Service users with severe and persistent mental illness, such as schizophrenia, severe depression or bipolar disorder

6.3 Longer term disorders of lesser severity but which are characterised by poor treatment adherence requiring proactive follow up

6.4 Any disorder where there is significant risk of self harm or harm to others (e.g. acute depression, anorexia, high levels of anxiety) where the level of support exceeds that which the primary care team can offer

…

6.6 Disorders requiring skilled and intensive treatments such as Cognitive Behavioural Based Therapy (CBT), vocational rehabilitation and medication maintenance requiring blood tests not provided in primary care

…

6.9 Where resources allow psychological treatments can be provided for other mental health problems such as phobias, panic attacks, post traumatic stress syndrome. Some preventative work may also be undertaken on a short term basis for people who are suffering or have suffered serious life stresses

6.10 For those people who cannot be offered a service, information and help will be available in order to direct them to other services in the community such as Relate, HAPAS, Drugsline, Citizens Advice Bureau and a variety of community based counselling services'

14.10 Mr A's primary diagnosis was of personality disorder. While Mr A also demonstrated symptoms of drug and alcohol misuse, such behaviours are frequently used as

coping mechanisms by those patients suffering from a personality disorder and additional support is required while such maladaptive coping mechanisms are replaced.

14.11 The set of eligibility criteria outlined at Paragraph 13.9 above does not specifically include individuals with personality disorders. However, Consultant Psychiatrist 1 continued to attempt to engage with Mr A, despite the diagnosis of personality disorder and did attempt to utilise the expertise of existing services on Mr A's behalf. This is an element of good practice.

14.12 For example, on 9 November 2006, Consultant Psychiatrist 1 requested information from the Cassel Hospital in relation to the possibility of Mr A receiving residential treatment there. The Cassel Hospital is a specialist residential unit for the treatment of severe and complex personality disorders. On 7 December 2006, it was confirmed that there was sufficient justification for Mr A to receive inpatient treatment at the Cassel, although it would be jeopardised by Mr A's return to drugs, alcohol or violence. However, on 9 January 2007 Consultant Psychiatrist 1 was informed that funding was not available for Mr A to receive inpatient care at the Cassel Hospital due to the absence of a funding agreement.

14.13 At the time of Mr A's contact with the CMHT in 2005-7, one of the services provided by HPFT was a Community Drug and Alcohol Team (CDAT), however, Mr A was not referred to CDAT at any point during his treatment. Mr A was in contact at various points during his treatment with external drug and alcohol counselling services including Druglink, Focus and Alcoholics Anonymous.

14.14 Mr A also considered for residential treatment in December 1998 in relation to his drug and alcohol abuse issues. Between July and September 1999, discussions as to the suitability of residential treatment for Mr A's drug and alcohol issues were carried out. Funding was made available for a place at Yeldall Manor, but Mr A refused to engage with this referral (potentially as a result of ongoing criminal charges). As a result, Mr A was discharged and referred to the Focus Project, a drug and alcohol community service which is not run by HPFT.

14.15 Dedicated Personality Disorder Service

14.16 At the time of Mr A's care, HPFT did not have a specialist service dedicated to the care and management of patients with personality disorders. HPFT established a multidisciplinary Community Personality Disorder Service (CPDS) in 2009 that now

provides a range of treatment options including CBT and DBT therapy alongside providing support with social issues including drug and alcohol problems.

14.17 In August 2012, the HPFT CPDS was invited to join the National Community Personality Disorder Innovation Network and was selected to be one of only 15 Community Innovation pilot sites responsible for testing different ways of working with people with personality disorder, following investment from the Department of Health.

14.18 The main benefits for HPFT from being part of the National Innovations Personality Disorder Network are that it:

- Raises the profile of best practice in treating personality disorders in the HPFT area;
- And provides access to Experts by Experience (people who have experienced and are living with personality disorders and can advise service providers and users involved in service development).

14.19 The introduction of a dedicated multidisciplinary service for individuals with personality disorders is an element of best practice.

14.20 It is clear that had this service been available in 2007, Mr A could have been sign posted there in order to receive multidisciplinary care targeted toward the needs generated by the issues which he faced. It is clear that the availability of such a service reduces the risk of an individual with a combination of personality disorder and substance misuse falling through the gaps in service provision and can provide improved case management and pathways of care.

14.21 Key Points

1. Mr A was diagnosed with a personality disorder. His specific diagnosis changed over time but antisocial and borderline traits were repeatedly identified by psychiatrists involved in his care.
2. Consultant Psychiatrist 1 at Dacorum CMHT maintained contact with Mr A and attempted to coordinate his needs through the CMHT. Consultant Psychiatrist 1 was able to establish a relationship of trust with Mr A. Consultant Psychiatrist 1 signposted Mr A to a range of community services which were available to him at that time. This is an element of good practice. Mr A did not always comply with referrals made by Consultant Psychiatrist 1 in this respect.
3. In 2007, HPFT did not have a dedicated multidisciplinary Personality Disorder Service. This meant that the complex and challenging needs of an individual such as

Mr A had no alternative but to obtain care from a variety of sources with the attendant risk that his needs could fall between the gaps in service provision.

4. A dedicated personality service was established by HPFT in 2009. This is an element of best practice that was not available to Mr A in 2007.

15.0 CARE PROGRAMME APPROACH

15.1 Care Programme Approach Policy Requirements

15.2 The Care Programme Approach (CPA) is the framework for care co-ordination and resource allocation within mental health, as laid down by the Department of Health in 'Effective Care Co-ordination in Mental Health Services' (1999).

15.3 The Operational Policy which was in force throughout the time Mr A was receiving care states at Section 16.1:

> *'16.1 The Care Programme Approach (CPA) is the framework for care co-ordination and resource allocation within mental health and should be an effective, efficient and transparent process of care co-ordination and care delivery that encompasses all the relevant responsibilities of the NHS and the local authority.'*

15.4 Further, the Operational Policy stated:

> *'16.2 Following a comprehensive assessment of health and social care needs and a risk assessment all service users requiring a service will be allocated a named Care Co-Ordinator and a level of CPA, Standard or Enhanced, agreed. A care plan will be formulated.*
>
> *16.3 The Care Plan will include details of services required to meet need and manage the assessed risk, and Contingency Plans which will identify risk factors, early warning signs and actions to be taken in any crisis.*
>
> *16.4 It should be recognised that risk cannot be eliminated, only managed. An integral part of the management process should be for the service user to accept responsibility for their own actions and associated risks supported by the Care Plan and the team's interventions.*
>
> *…*
>
> *16.6 The comprehensive assessment will be recorded on form CP2 which will be entered onto Care Notes or held on file. The risk assessment and Care Plan will be recorded on the relevant CPA documentation for Standard or Enhanced level and this will also be entered onto Care Notes (or held on file). When service users have been seen at an out-patient clinic the assessment and Care Plan is likely to be in the form of a letter.*
>
> *16.7 The service user and relevant carers (if agreed) will receive a copy of the care plan and the risk management plan. They will be encouraged to be involved in the planning process and express their views on the content of the Care Plan.*
>
> *…*

16.10 CPA and risk assessment reviews will be held at regular intervals, according to need, and at no less than annual intervals. GP's are invited to all CPA meetings and their attendance at critical meetings essential.

…

16.12 Transfer of care to another area will be managed by the Care Co-Ordinator according to policy guidelines.

16.13 CMHTs will comply to all the requirements of the HPT Policy on 'Care Programme Approach Incorporating Care Management.'

15.5 At the time of Mr A's care, HPFT's policies and procedures relating to CPA were contained in the Integrated Care Management Approach and Care Management Policy (the 'CPA Policy'). This was dated October 2004 and was due for review in 2006. The CPA Policy stated that CPA has four key parts:

- The systematic assessment of an individual's health and social care needs including the level of risk;
- The development of an appropriate and agreed care plan to meet those needs;
- The allocation of a Care Co-ordinator to co-ordinate the delivery of care and ensure all involved in the care plan are kept informed of any changes; and
- The regular review and monitoring of the service users' progress and the delivery of the care programme.

15.6 Under this policy the CPA is applicable once a patient has been assessed and accepted by a specialist mental health service. A needs assessment and a risk assessment should be carried out in order to ascertain the appropriate level of CPA for an individual.

15.7 In considering Mr A's care in the period leading up to the death of the Deceased, the Independent Investigation Team has focused upon whether the aims of the CPA as set out above have been addressed in accordance with the stages set out at Paragraph 14.5 above.

15.8 CPA Level

15.9 There are two levels of CPA – Standard and Enhanced, relating to the needs of and the risks posed by the patient. The decision as to which level of CPA is appropriate is made by the care co-ordinator for a patient. The CPA Policy states that the decision should be made on the basis of which level is appropriate to manage the needs and risk of the individual service user.

15.10 The characteristics of an individual for whom the Standard CPA approach is appropriate, as laid down by the CPA Policy at Section 11.1, include some of the following:

- 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;
- They require the support/intervention of one agency or discipline.

15.11 The characteristics of service users on Enhanced CPA, as set out at Section 11.2 of the CPA Policy, are stated to include at least one of the following:

- They are only willing to co-operate with one professional or agency but have multiple care needs;
- They may be in contact with a number of agencies (including the criminal justice system)
- They are 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 because of their mental health problems;
- They are more likely to disengage from services or not comply with treatment;
- They have multiple care needs which require multi-disciplinary or interagency coordination.

15.12 Mr A was initially assessed for the CPA on 27 May 2002. Throughout his care, he remained on the Standard CPA. The Independent Investigation Team discussed the decision to maintain Mr A on the Standard level of CPA with Mr A's care co-ordinator, Consultant Psychiatrist 1 at Dacorum CMHT. He stated:

> *'C Psychiatrist 1: When a patient is seen only by myself it is always standard CPA. It's, unless there is a particular reason why it should be enhanced. It is usually enhanced when a patient is seen by more than one professional, so if a patient is care co-ordinated by a member of the Community Mental Health Team and other services are involved then the CPA level will be enhanced.'*

15.13 Mr A's care co-ordinator went on to state:

'*C Psychiatrist 1:* *…coming back to standard or enhanced, it's almost academic.*

JH: *I was going to ask that – what, what difference does it make if you're the care co-ordinator –*

C Psychiatrist 1: *I could – I would – still be the care co-ordinator because he didn't merit to be allocated someone from the CMHT. Then the-...how can I explain that to you, we have a small number of personality disorders who are care co-ordinated by CMHT members. Usually it's because they are in need of being seen quite regularly because of their acting out behaviour, they end up in A&E with para-suicidal gestures, and therefore there's a lot of concern raised in the community, and someone needs to deal with it. And then it's often an allocated CPN and a social worker from the CMHT who looks after that patient. But Mr A wasn't someone who would regularly turn up in A&E, or come to my attention because of other behaviour in the community. He had – as you can see, there were long spells where he was working with agencies outside CMHT, Probation Service, Drug & Alcohol services as you can see. There has been, there are reports from the drug and alcohol lady in Watford, also the family therapist who worked with him for lengthy periods, and they would then report back to me. So there wasn't a real need for him to be allocated a CPN or social worker, nor would we have the manpower to do so. And I was – I was perfectly happy to care co-ordinate him on my own.*

TC: *OK, and that's what I want to check, was whether or not he was defaulted to you because of lack of manpower, or because actually that was the most clinically appropriate thing to do.*

C Psychiatrist 1: *I think it was a clinically appropriate thing to do, and I would have difficulty asking my Team Manager to allocate one of the CPN or social workers to him, but because - what would be the role of that person, other than what I was already doing? Because the referrals and the, the, the communication with the GP and the referrals to the Cassel Hospital and the Henderson Hospital could not be done by CPN but should be done by me. So it would- it would still come back to me.'*

15.14 The Independent Investigation Team is concerned by the decision to maintain Mr A on a standard CPA throughout his care.

15.15 During his lengthy involvement with Dacorum CMHT, Mr A was in contact with the following agencies at various times:

- Drugcare St Albans (drug and relationship counselling)
- Relate (anger management, impulse control and 'think first' counselling)
- Hertfordshire Social Services (child access/custody proceedings)
- Children Schools and Families (regarding risk to unborn child)
- Jamma Umoja Centre in Croydon (observation of parenting skills/part of long assessment ordered by the Court to review arrangements for new baby)
- CBT with Consultant Psychologist 1 (to continue anger management work)
- Turning Point (drugs and alcohol counselling)
- Mr A was also engaged in the MAPPA process (multi-agency management of risk of harm to the public).

15.16 Mr A presented with a number of features which are characteristics of service users on Enhanced CPA, as set out at Section 11.2 of the CPA Policy, including:

- Greater risk of harm to self and others;
- Multiple care needs requiring multidisciplinary or interagency co-ordination;
- Contact with a number of agencies including probation, social services, and Children Schools and Families.

15.17 Enhanced CPA imposes a greater degree of formality on the process of monitoring a service user and of ensuring that care is provided in an appropriate manner. It also requires an enhanced risk assessment be carried out in relation to the service user. A further benefit to the service user is that when an individual is placed on enhanced CPA, the care co-ordinator is required to convene a meeting of relevant parties in order to agree an enhanced CPA care plan. Consequently, a degree of multidisciplinary decision making and consideration is introduced for the benefit of the service user, which may not apply to individuals on the standard CPA basis.

15.18 Mr A presented with complex difficulties including psychological, health, social and substance use issues. This can make the clinical decision making process more complex and difficult. Multidisciplinary team working provides a skill range to enhance the provision of care for complex individuals. The Independent Investigation Team are concerned that in allocating Mr A to standard level CPA, the features of Mr A's individual presentation were not given sufficient consideration. It appears to the Independent Investigation Team that instead resourcing issues may have been a factor.

15.19 Notwithstanding the designation of Mr A at the standard level of CPA, it would have been open to those responsible for delivering Mr A's care to have used elements of the enhanced level of care such as the 'enhanced' risk assessment to develop strategies relating to his care. If used effectively, the CPA process can be adapted in terms of process in order to best suit the needs of the individual who is the subject of care. However, in order to do this, there must be recognition of CPA as a mechanism of care planning in order to meet the needs of individuals as opposed to it being a bureaucratic process which impedes or adds to practitioners' workloads.

15.20 During the course of the Investigation HPFT were asked to supply details of how the allocation of cases to standard or enhanced level of care within CMHTs is now audited and kept under review within the requirements of its internal procedures to prevent a similar concern arising in the future

15.21 HPFT responded as follows:

'The Care Co-ordination Policy was reviewed following the publication of DOH guidance "Refocusing the Care Programme Approach" (2008). Since then, cases have been managed under either the CPA or Standard Care. This revision of the policy was supported by clear communication to CMHT managers and others about the key changes including the criteria for CPA and Standard Care.'

'Aspects of care co-ordination are audited each year as part of the Trust's Clinical Effectiveness programme. In addition, the Trust uses the national service user survey to benchmark its application of the two types of care co-ordination against other Mental health Trusts nationally. We consistently find that we are near the mean for this. For example, in July 2013 we are at 28% of those under care co-ordination being on the CPA.'

15.22 Key Points

1. Mr A was entered into the CPA on 27 May 2002.
2. Mr A remained on standard CPA throughout his care. This is a matter for concern for the Independent Investigation Team as there were many factors in Mr A's presentation which would have suggested that enhanced CPA care was more appropriate for his individual presentation.

3. Enhanced CPA would have provided Mr A with access to multidisciplinary team consideration and indeed, decision making, together with enhanced risk management processes.

15.23 Recommendation

1. HPFT should incorporate into its audit plan, an audit to determine whether the criteria for standard care or CPA are being correctly applied.

15.24 CPA Review / Care Planning

15.25 The management of individuals with personality disorder is often challenging. Patients with personality disorder have multiple and diverse needs. Although there are a number of difficulties in managing patients with personality disorder, the Independent Investigation Team is of the view that their problems are easier to tackle if the patient's individual needs are identified and an appropriate plan is formulated and kept under review as circumstances change over time.

15.26 Patients with personality disorders often present with complex difficulties and no single treatment intervention is likely to meet their diverse needs. They may need several types of help, delivered by a team of professionals. Treatment and intervention will not be purely psychological but may also need to include help with the disabling effects on social functioning that a personality disorder can cause. Social problems such as housing, finances, employment and family relationships may need to be tackled.

15.27 The CPA Policy gives the following guidance in respect of CPA Care Plans:

'13.1 The Minimum Requirements of a Care Plan

A service user, whether on Standard or Enhanced CPA, must receive a written copy of their care plan. The care plan should be devised and written with the optimal involvement of the service user, using the service user's preferred form of words where possible. … The care plan must:

- *State the CPA level and Care Co-ordinator's name and contact details*
- *Identify the interventions and anticipated outcomes*
- *Record all the actions necessary to achieve the goals*
- *Set out estimated timescales by which outcomes or goals will be achieved or reviewed*
- *Describe the contributions of all agencies involved*
- *Include a contingency plan*
- *Be understandable and meaningful to the service user*
- *Be agreed by the service user and signed by them (the electronic patient record may not be signed).*
- *Be signed by a representative of the Clinical Team.'*

15.28 In relation to the review of CPA Care Plans, the CPA Policy states:

'14. Care Plan Review Arrangements

There is no predetermined frequency for a review meeting as this is determined by the needs of the service user. However all service users on Standard and Enhanced CPA should have a minimum of one review per year.

The purpose of a CPA review is therefore:

- *To review the working of the care plan and risk management plan*
- *To revise the care plan and risk assessment as necessary*
- *To review any care commissioned under care management arrangements*
- *To consider the appropriateness of the CPA level the service user is allocated and whether there is a need to alter this or discharge the individual from the CPA system.*

<u>14.1 Standard CPA Review</u>

For service users on Standard CPA, the Care Co-ordinator will review with the service user, the care plan and risk assessment and its appropriateness on a regular basis. This must occur at least once a year. Changes or amendments to the care plan will be confirmed to the service user in accordance with the system of documentation in use (see 13.3 above).'

15.29 The Dacorum CMHT Manager was interviewed in relation to the requirements for review of a service user's CPA. He said:

'*TC: How often is the CPA reviewed? How often do people have a CPA?*

D CMHT M: *Right, in terms of the, the absolute sort of minimum, would be, be an annual review and, and certainly anyone on standard CPA should, should have a review annually. Depending on, on the situation, the risk of concerns, a service user may have more CPA, so that's, so there's, there's a basic sort of minimum and it, after that, there may be well more CPAs within that, depending on the situation and, and risk.*

TC: *And how is that, how would you know if somebody, if somebody didn't have one? How is that monitored?*

D CMHT M: *That is recorded on the Cognos database. We do have a report, reports of currently of* [sic] *service users who have gone 365 days since their last CPA review and we, we start to get alerted to service users who are approaching this deadline. Some at 9 months in advance of that. So we start to get reports saying that, that an annual review is needed. And this is increasingly more closely monitored because as, I keep on using the word targets, but there is a target to*

ninety-five per cent or CPA reviews need to be completed within 365 days.'

15.30 Consultant Psychiatrist 1 wrote to Mr A's GP describing the outcome of consultations of Mr A on three occasions in the 18 months prior to the Deceased's death, on 11 April 2006, 16 August 2006 and 12 October 2006. The Independent Investigation Team recognises that the CPA Policy states:

'13.3 Standard CPA Care Plan

For individuals assessed as requiring Standard CPA, the identified Care Co-ordinator will utilise their own clinical records as documentary evidence of the assessment, care planning and review processes attached to CPA. Risk assessments should be recorded on the Standard Risk Assessment form.
The Care Co-ordinator is responsible for ensuring each service user is provided with a copy of their care plan which they can sign and keep, along with information about how they may contact their care co-ordinator and contingency plans in the event of the care plan breaking down.'

15.31 The Independent Investigation Team could find no evidence of a structured CPA care plan within Mr A's records in the eighteen months prior to the Deceased's death. The Independent Investigation Team found it difficult to determine what treatment goals had been set for Mr A, how his progress was to be assessed objectively and what timetable was to apply. This is a matter of significant concern. A particular concern is that there does not appear to have been any contingency plan in the event that Mr A failed to attend appointments or engage with services. Such a plan could have been discussed with Mr A in advance and could also have involved Mr A's carers or next of kin. This is a common practice when a patient is known to have substance use issues, suicidal/parasuicidal behaviour, or finds himself of no fixed abode from time to time.

15.32 The Independent Investigation Team also note that an individual on enhanced CPA would receive multidisciplinary consideration when a review of their CPA requirements became necessary. Mr A did not receive multidisciplinary review of his care plan or his CPA at any stage in his care.

15.33 For example, the Independent Investigation Team noted that there were a number of circumstances that could have prompted a review of Mr A's Care Plan. An example of this was the decision by the MAPPP to re-register Mr A at Level 3 on 8 January 2007, the highest level of risk, following threats to a social worker from Children Schools & Families. It is the view of the Independent Investigation Team that this

could have prompted a review of Mr A's Care Plan to produce a risk formulation which was dynamic and up to date and which could be shared with all those individuals involved in Mr A's care. This is a matter of significant concern.

15.34 There is evidence within Mr A's records that his care co-ordinator did seek assistance from other practitioners and care providers on behalf of Mr A, in an attempt to address some aspects of his presentation which cause practical difficulties in his day to day life. For example, Consultant Psychologist 1, a Consultant Psychologist at St Albans CMHT, was approached to obtain help for Mr A in dealing with difficulties in his relationship with Social Services. Mr A was in a dispute with Social Services due to the reluctance of Children Schools and Families to allow him to live with his 6 month old daughter and partner. This is an element of good practice. However, it is difficult to understand from Mr A's records how this referral came about other than it having been generated by a request by Mr A. By allowing Mr A to take the lead in this process, the likelihood of Mr A's engagement in therapy was increased. However, it is difficult to ascertain how this fitted into any overall documented care plan which had been identified in relation to Mr A's care. This is a matter of concern for the Independent Investigation Team.

15.35 The Independent Investigation Team is concerned that it could not find any evidence in Mr A's records of a systematic CPA review of Mr A's care and risk management plans or indeed needs assessments during the eighteen months prior to the Deceased's death. This is a matter of significant concern.

15.36 The Independent Investigation Team are concerned that Mr A was not copied into his care co-ordinator's correspondence with Mr A's GP. Given that there were no other documents which could have acted as his care plan, it raises a question as to what Mr A's understanding of the basis of the care with which he was being delivered was. This is a particular concern given his pattern of non-engagement. It is possible that a clear outline of goals and a set of shared expectations could have helped the relationship between Mr A and his care providers in times when it came under strain.

15.37 There is evidence in Mr A's records that he may not have fully understood aspects of his care. For example, Mr A was seen on 24 October 2006 by Consultant Psychologist 1. Consultant Psychologist 1's note of the consultation includes the following reference:

> *'It was explained to him that this contact will be limited to six sessions. Initially, he was resistant to the notion that he would have to use progress gained to*

cope alone, asking where else he will be referred and whether residential care would be available, but accepted the point that progress involves being able to cope without indefinite support.'

15.38 The Independent Investigation Team understand that changes to practices and procedures within HPFT are now in place to ensure that CPA reviews are carried out annually for service users on standard CPA.

15.39 During the course of the Investigation HPFT were asked to provide a detailed account of what changes have been made to procedures to ensure that CPA planning is undertaken and reviewed in respect of all service users, including details of the level of CPA and the monitoring arrangements put in place to ensure the quality of the CPA review process itself.

15.40 HPFT responded in the following terms:

'The Trust's approach to care co-ordination has been regularly updated since 2007, starting with the major review in 2008. Practice has been developed over the years – to respond to best practice guidance and to reflect the personalisation agenda and the recovery model to which we are committed.'

'Some key changes are as follows:

- *The types of care co-ordination to be used are CPA and Standard Care.*
- *The criteria for CPA are clearly stated; all those who are inpatients or under the care of the crisis teams are on CPA.*
- *All those on CPA on discharge from the acute care pathway receive 7 day follow up.*
- *Transfer meetings are held when service users transfer from one service to another or one Trust to another.*
- *To reflect the 2008 guidance, reviews take place at least annually but they do not have to be through formal review meetings if that does not suit the service user.*
- *Psychiatrists are not expected to act as CPA care co-ordinator unless there are exceptional circumstances.*
- *All those under care co-ordination have a named care co-ordinator and a review of their needs at least annually, confirmed in a written care plan of which they have a copy. For those under psychiatric outpatients care only, this will be the GP letter.'*

'At least one audit per year checks compliance with these Trust standards. This has included reports on whether Consultants are always copying GP letters to service users, and whether transfer meetings are being held as stated in the policy to ensure safe transfer of responsibilities. We have also used the national Suicide Prevention

audit toolkit to examine practice with regard to care co-ordination and management of clinical risk – this includes consideration of whether the levels of care co-ordination are being correctly applied.'

'The annual national service user survey provides a good chance for us to measure our performance against the national picture. It asks detailed questions about the service user's experience of the review process.'

15.41 Key Points

1. The Independent Investigation Team could not find any evidence of a comprehensive CPA care plan within Mr A's notes.
2. The Independent Investigation Team could not find any evidence of any CPA reviews taking place in relation to Mr A's care in the eighteen month period prior to the Deceased's death. This is despite significant changes taking place in Mr A's circumstances during this time.
3. Consultant Psychiatrist 1 wrote on a number of occasions to Mr A's GP. These letters were not copied to Mr A and they did not meet the requirements of a care plan set out in the CPA Policy. This is a matter of significant concern.

15.42 Recommendations

1. Many of the concerns highlighted by the Independent Investigation Team have been addressed in systematic changes made by HPFT. However, the Independent Investigation Team note that a patient transferring from a local team to another local team within the same service are not the subject of a formalised procedure or protocol. The Independent Investigation Team believes that a formalised procedure should be adopted in this regard.

2. The Independent Investigation Team believes that the allocation of a psychiatrist as a co-ordinator is acceptable in exceptional circumstances. However, these circumstances should be identified in a procedure which includes an element of multidisciplinary working.

15.43 Risk and Needs Assessment

15.44 Effective clinical risk assessment and management is the process of collecting relevant clinical information about the service user's history and current clinical presentation to allow for a professional judgement to be made identifying whether the service user is at risk of harming themselves and/or others, or of being harmed themselves.

15.45 The assessment, documenting and management of risk is an essential component of all clinical assessments undertaken by members of health and social care staff. Risk assessment and CPA procedures are intrinsically linked. An assessment of risk will form part of a needs assessment.

15.46 The assessment and management of risk should be a multidisciplinary process which must include, where possible and appropriate, the service user and their carer(s). This is because engagement and compliance are more likely if individuals have been given an opportunity to buy into the process. Decisions and judgements should be shared amongst clinical colleagues and documented early.

15.47 At the time of Mr A's care, HPFT had in place the 'Clinical Risk Assessment and Management for Individual Service Users Policy and Procedures' dated October 2005 (the 'Risk Assessment Policy').

15.48 The Risk Assessment Policy requires care co-ordinators (in the case of an individual on Standard CPA) or the multidisciplinary team (in the case of an individual on an Enhanced CPA) to gather relevant information relating to the risk posed by an individual and to consider all such information in the process of carrying out a risk assessment. It emphasises that, as more information becomes available, the risk assessment and care plan should be updated having taken any new information into consideration.

15.49 The Risk Assessment Policy also imposes a requirement that situations likely to create increased risk of harm be identified, and that this be carried out, where possible, in a multi-disciplinary setting to maximise the potential for risk to be considered and discussed.

15.50 The Risk Assessment Policy specifically states, in relation to recording risk assessments:

> *'The risk status of a service user is a key item of information and must be recorded on the appropriate forms as described below. A copy of the*

assessment must be filed on the care record. Where separate records are held, for example when there are separate medical, nursing or social care notes, a copy must be placed on each file.

The Care Co-ordinator is normally responsible for ensuring the appropriate risk assessment is completed (during an in-patient admission the role may be delegated to the named nurse). For Standard CPA (or equivalent substance misuse services) this may be an individual worker. For Enhanced CPA (or equivalent substance misuse services) this will be the designated Care Co-ordinator or named nurse in discussion and agreement with the multi-disciplinary team.'

15.51 In addition, the CPA Policy states:

'10. Risk Assessment

The assessment, documenting and management of risk is an essential component of all clinical assessments undertaken by members of HPT health and social care staff. Risk assessment and CPA procedures are intrinsically linked. A risk assessment coupled with a needs assessment will assist the assessor in determining the most appropriate level of CPA for an individual service user.

An assessment of risk will form part of a needs assessment. As a minimum standard this should be documented on the relevant documentation as determined in the Policy Guidance concerning Risk Assessment and Management Procedures.'

15.52 The Criminal Justice Act 2003 provided for the establishment of Multi-Agency Public Protection Arrangements (MAPPA) in England and Wales. These are designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. They require the local criminal justice agencies and other bodies dealing with offenders to work together in partnership in dealing with these offenders.

15.53 MAPPA is a mechanism through which agencies discharge their statutory responsibilities and protect the public in a co-ordinated manner. Agencies at all times retain their full statutory responsibilities and obligations. Through this mechanism, violent and sexual offenders can be assessed at one of three levels based on an assessment of risk.

15.54 MAPPA Level 2 indicates a need for multi-agency management of an offender's risk. MAPPA Level 3 is the highest level and is reserved for a small number of individuals who have been assessed as posing high or very high risk of causing serious harm

and presents risks that can only be managed by a plan that requires close cooperation at a senior level. It requires MAPPP meetings to take place with senior representatives of different agencies involved in management of the individual and for greater resources to be used in management of these individuals.

15.55 Mr A was assessed at the following times through the MAPPA:

Date	**MAPPA Level**	**Reasoning**
1 April 2005	Registered at Level 3	Violence against his partner.
11 December 2006	De-registered	Mr A's reported behaviour was deemed not to be causing concern
8 January 2007	Re-registered at Level 3	Threats made to a social worker. The assessment of risk of serious harm was raised to 'High'.
12 February 2007	Maintained at Level 3	The assessment of risk of serious harm was maintained at 'High'.
11 April 2007	Lowered to Level 2	It was felt that Level 2 management was now appropriate. No new actions were planned by agencies involved in his management to manage risk. The assessment of risk of serious harm was maintained at 'High'.
09 May 2007	Maintained at Level 2	The assessment of risk of serious harm was maintained at 'High'.
13 June 2007	Maintained at Level 2	The assessment of risk of serious harm was maintained at 'High'.

15.56 In addition, a risk report undertaken by a Chartered Forensic Psychologist working for the Probation Service in Oct 2005, referred in more detail to at Paragraph 9.30 of this report, provided those involved with Mr A an assessment of his static violence risk via the Violent Risk Appraisal Guide (VRAG). The VRAG suggested that 55% of offenders similar to Mr A would reoffend in a violent manner within the next seven years and that Mr A may be at risk of committing either domestic or stranger violence in the future. The PCL-R assessment was also completed and suggested Mr A had moderate psychopathy and highlighted specific areas of concern. In addition this report highlighted some potential dynamic risk factors such as use of substances, exposure to stressful situations, loss of employment, and difficulties gaining access to his child.

15.57 As a result, Mr A's risk was well known to those involved in his care and indeed in the period leading up to the Deceased's death it appeared to those involved in the MAPPA that it was appropriate to reduce his level of MAPPA management.

15.58 However, the Independent Investigation Team were unable to identify a Risk Assessment or indeed needs assessment completed by Mr A's care co-ordinator within his medical records which reflected these changes in Mr A's presentation of risk. There does not appear to be a single document which represents a comprehensive summary of Mr A's risks or all the concerns which those involved in Mr A's care had about him at key stages in his presentation, or when significant events such as registration at MAPPA Level 3 occurred or indeed when he was subsequently moved to MAPPA Level 2. This is a significant concern for the Independent Investigation Team.

15.59 The Independent Investigation Team's concern is that in failing to review Mr A's risk on a formal basis, his care co-ordinator was not in a position to properly identify and assess his current dynamic risk factors or manage his current or potential future risk factors effectively.

15.60 Mr A's presentation was complex and included an extensive offending history. The Historical, Clinical, Risk Management-20 (HCR-20) is an assessment tool that helps mental health professionals estimate a person's probability of violence. The clinician gathers qualitative information about the person being assessed guided by the HCR-20. The HCR-20's results help mental health professionals determine best treatment and management strategies for potentially violent individuals. A HCR-20 assessment would identify both static historical risk factors but also clinical dynamic factors and potential future risk management issues to consider.

15.61 The HCR-20 does not allow for a definite prediction of violence. Predictions of violence based on the HCR-20 may be offered using probabilistic statements such as 'low', 'moderate' or 'high' but risk varies over time and according to circumstances. Study of the HCR-20 factors can lead to an understanding of situations and states of being that may dispose a person to violence or help insulate them against it. Consideration of such factors can assist in identifying the type and extent of risk presented by a person and in devising a risk management plan that includes intervention strategies intended to reduce the probability that an individual will demonstrate violence.

15.62 The Community Forensic Operational Policy makes it clear that it is able to undertake assessment procedures such as the HCR-20, RVSP and PCL-SV.

15.63 Neither Consultant Psychologist 1 nor Consultant Psychiatrist 1, who were most closely involved in Mr A's care, were trained in this risk management tool and therefore could not have undertaken this assessment using this tool. However, a referral could have been considered by Mr A's care coordinator to the Community Forensic Team or Probation Service in order that this key aspect of Mr A's presentation was managed, particularly when Mr A's MAPPA Level rose to Level 3. An HCR-20 was not completed at any stage in Mr A's involvement with mental health services.

15.64 During the course of the Investigation, HPFT were invited to supply information that clinical staff within CMHTs are now trained in risk assessment tools, such as HCR-20.

15.65 HPFT were also invited to submit details of how HPFT ensures that the Risk Assessment and Management Policy is implemented and risk assessments are performed on all service users and how the quality of those care plans is assessed.

15.66 HPFT responded as follows:

'All frontline staff receives training at least every three years in clinical risk assessment and management. This is mandatory. The Clinical Risk policy and procedures are regularly reviewed to ensure they are compliant with best practice (for example, the DOH guidance "Best Practice in Clinical Risk Management". The training then reflects the policy.

The overall system for assessing clinical risk was reviewed in 2012 to make it more supportive of structured clinical judgment as recommended by the guidance. The available clinical risk assessment tools were evaluated and in some cases trialled – leading to a simplified standard risk assessment form.

To complement the standard form, staff have clear guidance about the risk assessment tools that are expected to also use in particular settings. For example, crisis team when assessing for suicide risk are expected to use the Beck Hopelessness Scale to inform their assessment. Staff in the forensic services are expected to use the HCR20 following training in its use - to assess for risk of violence. We have not considered it necessary to expect the use of the HCR20 in general community mental health services – especially as a forensic assessment internally can be obtained when there are concerns about risks of violence.

As with care co-ordination, clinical risk assessment and management is subject to at least one clinical audit per year. Both areas remain of critical importance in the avoidance wherever possible of serious incidents. For example, this year the clinical

risk audit examined how well risk assessments informed care plans and whether care plans could be seen to have been adjusted in response to changes in risk levels in individual service users.

Results are communicated to teams through our practice governance framework.'

15.67 Key Points

1. The Risk Assessment and Management Policy in place at the time of Mr A's care required care co-ordinators to gather information relating to the risk posed by service users to themselves and others as part of a risk assessment. It also required any situations likely to lead to an increased risk of harm to be identified and where possible discussed in a multi-disciplinary meeting.
2. A risk report was produced by a Forensic Psychologist in October 2005 that included an assessment of Mr A's static violence risk and identified some dynamic risk factors. This report suggested that 55% of offenders similar to Mr A would offend violently in the future and that there was a risk of both domestic and stranger violence.
3. Mr A was the subject of meetings of a Multi-Agency Public Protection Panel (MAPPP) during his care by HPFT. The purpose of a MAPPP is to enable co-ordination between services to manage certain individuals deemed to pose a significant risk and to determine Multi-Agency Public Protection Arrangements (MAPPA).
4. Mr A was registered at MAPPA Level 3, the highest level indicating a complex case posing serious risk, on 1 April 2005 following violence against his partner.
5. Mr A was de-registered from the MAPPA process on 11 December 2006 as his reported behaviour was deemed not to be causing concern.
6. On 8 January 2007 Mr A was re-registered at Level 3 as a result of threats made against a social worker. The risk of serious harm posed by Mr A was assessed as 'High'. On 11 April 2007 Mr A was registered at Level 2 as it was felt that Level 2 management was now appropriate. Mr A remained registered at Level 2 up to the death of the Deceased.
7. The risk presented by Mr A was known to those responsible for delivering his care. However, Mr A's care co-ordinator does not appear to have completed formal risk assessments of Mr A. There is no single document providing a comprehensive summary of the static and dynamic risk factors which could impact upon Mr A at key stages in his presentation or when significant events occurred. Examples of such events that could impact on Mr A's level of risk include loss of his employment, disputes over access to his child, loss of a relationship, and discharge from Consultant Psychiatrist 1 or indeed Consultant Psychologist 1's care. This has

implications for on-going assessment and management of risk and is a significant concern for the Independent Investigation Team.

8. Mr A's presentation was complex and included an extensive offending history. It would have been appropriate to carry out a HCR-20 assessment to identify and explore both static and dynamic risk factors relating to his presentation. Neither Consultant Psychiatrist 1 nor Consultant Psychologist 1 were trained in administering the HCR-20 and therefore were not in a position to undertake this assessment. However, a referral to Forensic or Probation services could have been considered by Mr A's care coordinator. This did not occur.

15.68 Recommendation

1. The Independent Investigation Team recommends that the referral criteria for risk assessment between services are reviewed to ensure that patients can be referred expeditiously in order that risk is managed effectively and expeditiously at all times.

15.69 Care Co-ordinator

15.70 Consultant Psychiatrist 1 was Mr A's care co-ordinator from 28 May 2004. Consultant Psychiatrist 1 first assessed Mr A following an admission to an inpatient unit on 27 May 2002 but was assaulted by Mr A when Mr A was informed he was to be discharged. Following this, Mr A was arrested and convicted for the assault. Notwithstanding this, Consultant Psychiatrist 1 agreed to assess Mr A on 28 May 2004 and took on a caring role from that point on. After an initially difficult start, Consultant Psychiatrist 1 said of his relationship with Mr A, in a letter to Mr A's GP:

'I will remain the RMO for Mr A for the foreseeable future because Mr A has difficulty trusting people and we go back a long time.'

15.71 The CPA Policy states that:

'Every service user whether allocated to Standard or Enhanced CPA, will have a named Care Co-ordinator.'

15.72 The CPA Policy also states:

'12.2 Care Co-ordinator's Responsibilities

The Care Co-ordinator's responsibilities include the following:

- *To provide support and care in a positive context that is as acceptable to the service user as possible*
- *To work with service users to maximise their participation within the care provision process and to enhance service users empowerment within the care system*
- *To act as a consistent point of contact for all parties involved in the care*
- *To encourage the service user to be registered with a GP and to work closely with the Primary Health Care Team involving other professionals as required*
- *To ensure a comprehensive assessment of the service user's health and social care needs is undertaken*
- *To assess potential risks to children, under the age of 18 years and any other vulnerable members of the household*
- *To ensure the necessary services are commissioned or accessed*
- *To ensure an up to date risk assessment, management and contingency plan is in place*
- *To ensure that the service user and other key individuals receive copies of the agreed care plan*
- *To assist in planning and monitoring the delivery of the agreed care package and documenting and communicating decisions made about it*

- *To pursue the entitlement of carers who provide regular and substantial care for someone with a severe mental illness for assessment of need in accordance with the relevant legislation*
- *To ensure that the minimum requirements of a CPA Care Plan are delivered*
- *To ensure the CPA minimum data set is complete (Form CP1 Part A) and updated as necessary*
- *To collaborate with other professionals and agencies to ensure contact is maintained with the service user and their carer.'*

15.73 It is important that the care co-ordinator is trusted by the service user and the service user's own views as to the most appropriate person for this role should be sought. With a service user like Mr A who has a significant pattern of non-engagement, it is important to maintain stability in their care co-ordination. Consultant Psychiatrist 1 managed to build and maintain a positive relationship with Mr A while treating him over a period of several years. This is a key element of the care co-ordinator's role and is to be commended in light of Mr A's significant issues in engaging with services.

15.74 However, notwithstanding the complexity of Mr A's presentation and his established relationship with Mr A, the Independent Investigation Team are concerned that Consultant Psychiatrist 1 may not have been the best choice of care co-ordinator for Mr A in light of Consultant Psychiatrist 1's other clinical commitments.

15.75 The CPA Policy states:

> *'For service users on Enhanced CPA the role of the Care Co-ordinator is likely to be time consuming and require frequent contact with the service user, carers and other services and agencies. It is therefore not recommended that senior medical staff undertake this role unless there are exceptional circumstances to make this appropriate.'*

15.76 For the reasons already set out at Paragraph 15.18, the Independent Investigation Team believes Mr A should have been placed on an enhanced CPA level. The Independent Investigation Team are concerned that as Consultant Psychiatrist 1 should not have been allocated the care co-ordination role for Mr A due to the complexity of Mr A's presentation and his involvement with numerous services, which would have resulted in a significant time commitment for a care co-ordinator. Consultant Psychiatrist 1 may not have had the capacity to correspond with all the necessary professionals and services involved with Mr A's care effectively as many functions of the care co-ordinator role which are set out at Paragraph 15.72 above were not evidenced in Mr A's records, in particular, an apparent failure to conduct

regular CPA reviews. In addition, Consultant Psychiatrist 1 did not appear to be able to attend meetings concerned with Mr A such as the MAPPP due to his other commitments. There is nothing in the records to suggest that a deputy was sent. The Independent Investigation Team understands that Consultant Psychiatrist 1 did contact members of the MAPPP to discuss Mr A in advance of meetings. However, this may have had an impact upon the quality of multidisciplinary discussion which is a key part of the MAPPA process.

15.77 In addition, the Independent Investigation Team could not identify a copy of a needs assessment within Mr A's notes in the eighteen months prior to the Deceased's death.

15.78 During the course of the Investigation, HPFT were invited to provide information upon how systems and policies have been implemented since the death of the Deceased to manage the allocation and workload of those mental health professionals who act as care co-ordinators for service users, taking into account the relevant time commitments.

15.79 HPFT responded as follows:

'We have paid close attention to the issue of who is best placed to take on the role of care co-ordinator in a multi-disciplinary team. It is recognised that a psychiatrist who is likely to have relatively infrequent direct contact with all those under his/her care is usually not well placed to be the CPA care co-ordinator where the ability to respond flexibly and engage with a range of partner agencies is key.

Thus the Care Co-ordination policy has been strengthened to say this should only happen in exceptional circumstances. It has not been ruled out entirely because colleagues and service users have said that it can be this clinician who has the best relationship with a service user and the advantages of this need to be appreciated.

It should be acknowledged that in the six years since the incident, pressures on Trust services and within that on the role of the care co-ordinator have increased significantly and we would not want to pretend that there are not still some challenges in this area. One of the aims of our current service transformation programme is to reduce the numbers of service users with low level contact with the Trust requiring care co-ordination. We are also moving to a position where, whenever possible, those who can manage their own care do so to a greater or lesser degree, as they move towards recovery.'

15.80 Key Points

1. Consultant Psychiatrist 1 was Mr A's care co-ordinator from 28 May 2004.

2. It is important that a service user trusts their care co-ordinator. Where service users have significant patterns of non-engagement, it is important to maintain stability in their care co-ordination.
3. Consultant Psychiatrist 1 maintained a positive relationship with Mr A. This is to be commended in light of Mr A's known engagement issues.
4. Mr A had a complex presentation and was involved with numerous services during his treatment by HPFT. The role of care co-ordinator was likely to require a significant time commitment. Consultant Psychiatrist 1 may not have had the capacity to carry out the necessary functions of the care co-ordinator.

15.81 Recommendation

1. The Independent Investigation Team are of the view that in the event that a Consultant Psychiatrist is a patient's designated care co-ordinator, structures should be put in place to ensure that this individual is supported in practical terms to fulfil this role and their other clinical commitments.

15.82 CPA and Carers

15.83 An integral part of the CPA process is inclusion of carers in an individual's care. The CPA Policy states:

> ***'9. Needs Assessment***
> *…*
> *Assessment of a service user should take full account of their current social and family context. This should include the composition of their household, their roles and responsibilities within their household and their wider social network. This assessment should encompass parenting or other caring roles of service users. Risks to vulnerable adults should be identified in line with the Hertfordshire Adult Protection Procedure.*
>
> *The assessment should also take account of the views of members of the social and family network about the service user's needs, including the impact which the service users mental health problem may be having on members of the of the social and family network. Staff have a duty to offer a Carer's Assessment to identified carers within the service users social network. The offer of an assessment and its outcome must be documented within the CPA documentation.'*

15.84 Mr A's mother and his partner were present at certain times in Mr A's presentation and played a part in his life throughout his contact with mental health services. Mr A's living arrangements were disrupted for a variety of reasons, including criminal convictions, disputes with his partner, and his own actions resulting in him being ineligible for council accommodation. At times he was resident in his mother's home and at other times was living with his partner.

15.85 It is clear to the Independent Investigation Team that Consultant Psychiatrist 1 was able to meet with Mr A's partner on a number of occasions. Mr A's mother and partner were at times supportive of him and could potentially have been considered as his carers. However, Mr A's records do not set out the reasons why they were not thought to be potential carers for Mr A or why their views were not considered to be a necessary part of the CPA process applied to Mr A. The Independent Investigation Team could not find any evidence in Mr A's records that Mr A's partner or mother had been offered a carer's assessment in accordance with the terms of the CPA Policy adopted by HPFT. This is a matter of concern.

15.86 During the course of the Investigation HPFT were invited to provide the Independent Investigation Team with details as to how carers are now involved in the clinical decision making processes regarding service users, particularly those who present an increased level of risk.

15.87 HPFT's response was as follows:

'Carers are seen as experts by experience and nowhere more so than in the field of risk assessment and risk management. Since 2008 a section has been added to the Clinical Risk policy to say that staff must involve carers in this work wherever possible.'

'Both the Trust's policy on confidentiality and information-sharing, and its practice guidance on working with carers, state clearly that staff must not "hide behind" regulations on confidentiality as a reason for not involving carers. It is our experience that when the issues are carefully explained, most service users fully understand the value of their carers being included.'

'Last year we signed up to the Triangle of Care as a model for working with carers, and this commitment was confirmed in our Carers' Strategy (2013).'

'We test out how effective we are in this area through carers' audits and through our local surveys (Having Your Say).'

15.88 Key Points

1. Consultant Psychiatrist 1 acted as Mr A's care co-ordinator from May 2004 until immediately prior to the death of the Deceased.
2. It does not appear that Mr A's mother or partner were considered as carers of Mr A at any given stage. It is also unclear as to why their views upon Mr A's presentation and difficulties were not incorporated into Mr A's care plan.

15.89 Recommendations

1. Staff must be encouraged to recognise and identify potential carers. HPFT should include in its audit programme an audit to determine whether carers are being correctly identified by practitioners.

16.0 DISCHARGE FROM CARE BY CONSULTANT PSYCHIATRIST 1 ON 27 MARCH 2007

16.1 In a report provided to Mr A's solicitors on 2 August 2006, Consultant Psychiatrist 1 confirmed that Mr A was no longer living in the catchment area for the Dacorum CMHT. However, Consultant Psychiatrist 1 continued to treat Mr A at Dacorum CMHT until 27 March 2007. Consultant Psychiatrist 1 informed the Independent Investigation Team that he continued to treat Mr A due to Mr A's difficulty in forming trusting relationships with medical professionals. Mr A had last attended an appointment with Consultant Psychiatrist 1 on 6 October 2006.

16.2 On 27 March 2007, Consultant Psychiatrist 1 wrote to Mr A's General Practitioner in the following terms:

> '*Mr A had an outpatient appointment with me today Tuesday 27 March 2007. He did not attend nor did I hear from him. He has now missed three consecutive outpatient appointments and, therefore, I have no other option but to discharge him from my caseload and transfer his care back to you.*
>
> *It is my understanding that the referral to the Cassel Hospital for further treatment will not be funded by the PCT and that this whole exercise has become futile since it came to my attention that Mr A's partner has split up from him and moved to a women's refuge in Cambridge. Mr A is living with his mother in Harpenden and it is my impression that he wants to claim his partner's council flat.*
>
> *At present, Mr A is not on any prescribed medication, nor do I see a need for him to be on medication. He has now moved out of the Dacorum area and I would suggest to you that if in the future Mr A is in need of psychiatric services that he should be referred to the St Albans Community Mental Health Team.*
>
> *I have not been able to formally write to Mr A about my decision to transfer his care back to his GP because I have not got his Harpenden address. Please feel free to share the content of this letter with him when he comes to your attention.'*

16.3 It is clear that Consultant Psychiatrist 1 took the view that at this time, Mr A did not require psychiatric services. At this stage Mr A was undergoing a short course of CBT treatment with Consultant Psychologist 1 at St Albans CMHT. Mr A had failed to attend an appointment with Consultant Psychologist 1 on 13 March 2007. Consultant Psychologist 1 had notified Consultant Psychiatrist 1 of this failure. Mr A had however attended 4 appointments out of a course of 6 appointments with Consultant Psychologist 1 by this time. Consultant Psychiatrist 1 remained Mr A's care co-ordinator throughout this time.

16.4 CMHT Discharge Policy

16.5 The overall HPFT Discharge Policy that was in force in the period leading up to the Deceased's death was dated November 2005. In relation to outpatient services, it states:

> *'Service areas should have a system in place to follow up non-attendance at appointments. Although there may be a number of reasons for repeated non-attendance a decision by the service user to discontinue treatment should be assumed as one of them. Service areas should develop specific protocols to follow up regarding persistent non-attendance which should include the assessment of potential risk to the service user. The GP and any other referrer must be informed. CMHT, care coordinator or other relevant agencies to be informed as appropriate.'*

16.6 The CMHT Operational Policy dated 2005 states, in relation to non-attendance:

> *'Should a service user refuse to engage with the CMHT or refuse to continue to accept services the situation will be discussed within a multi-disciplinary team meeting. Risks to self and others will be assessed and an action plan, dependent on risks and need, agreed. The GP will be informed immediately.*
>
> *All service users that fail to attend an out-patient appointment should be reviewed by the Responsible Consultant and the multi-disciplinary team.*
>
> *Any failure to attend 2 out-patient appointments must be reviewed by the Responsible Consultant and the multi-disciplinary team. A decision regarding further action will be taken based upon assessed risks to self or others. If the decision is to discharge, the service user and the GP will be informed immediately.'*

16.7 The CPA Policy in force at the time of Mr A's treatment states regarding discharge:

> ***'15. Discharge from CPA***
>
> *Within Mental Health Services for Adults of Working Age, a service user may only be considered for discharge from the CPA framework (Standard or Enhanced) if they are no longer required to remain in contact with anyone from the specialist mental health service. Specialist mental health services include Housing Support Teams and Community Support Teams offering drop-in, support or group work. The Care Co-ordinator should therefore remain in contact, even if the only source of contact with the service users, are the above services.'*

16.8 Consultant Psychiatrist 1's letter dated 27 March 2007 contains elements of good practice. Where a medical practitioner does not have an appropriate correspondence address for a patient it is reasonable to attempt contact via that patient's GP. At this

time Mr A's domestic circumstances were chaotic and he was living at times with his mother and brother at different addresses. Consultant Psychiatrist 1 also noted that Mr A was not on any prescribed medication at the time and recommended an appropriate care pathway should he present needing psychiatric services in the future. However, the letter also raises a number of concerns.

16.9 Good practice would have been to hold a pre-discharge CPA or multidisciplinary meeting or at least correspond with those involved in Mr A's care such as is suggested by HPFT's Operational Policy. This would have ensured that any potential risk could be discussed and managed. Consultant Psychiatrist 1 did not correspond with the MAPPP or other agencies in his capacity as Mr A's care co-ordinator to inform them of Mr A's discharge from his care or discuss Mr A's case at the MDT meeting for consideration, as required by the Operational Policy. This is a matter of significant concern.

16.10 Mr A's presentation was complex and his potential risk to himself and others was significant. Mr A's GP does not appear to have been involved in MAPPA proceedings. The letter of 27 March 2007 was the only information sent to Mr A's GP regarding his discharge and does not refer to any risk assessment having been undertaken at this time. This is a significant concern.

16.11 A further particular concern for the Independent Investigation Team is that Consultant Psychologist 1 had not completed Mr A's course of CBT on 27 March 2007. Consultant Psychiatrist 1, by discharging Mr A without notifying Consultant Psychologist 1, left Consultant Psychologist 1 in a very precarious situation. Essentially, Consultant Psychologist 1 was in the position that he was providing care to a complex individual without a care co-ordinator managing Mr A's multi-agency involvement.

16.12 It is the view of the Independent Investigation Team that as a result of Consultant Psychologist 1's on-going involvement with Mr A, Mr A should not have been considered for discharge without a CPA meeting having taken place or indeed a MDT meeting having been arranged to discuss issues relating to risk following Mr A's discharge from Dacorum CMHT. This meeting would ideally have included Consultant Psychologist 1, whose view may have impacted upon the decision to discharge/transfer Mr A. The Dacorum CMHT Manager was asked about procedures for discharging patients who failed to attend in interview. He said:

'D CMHT M: *There isn't a sort of a three strikes, miss three appointments and you're out type policy within CMHT. As, as my reading of the, the discharge policy, the consultant can discharge back to the GP if service user fails to attend numerous outpatient appointments. But it also does suggest to the, to the consultant that, or to the care coordinator that they need to consider risk and to see whether there needs to be further discussion. In this case, I mean, I believe this sort of decision to discharge after three failed appointments should have prompted some further discussion within the multi-disciplinary team.'*

16.13 Consultant Psychiatrist 1 was also asked in interview about his decision to discharge Mr A back to the care of his GP. He said:

'C Psychiatrist 1: *Whenever he needed me he would come to my doorstep, and as I can show you, when he missed an appointment in August, I think 2006 then he turned up a couple of days later. When he needed me, he found me.*

JH: *Right.*

C Psychiatrist 1: *So when he didn't – and this is also commonplace with people who suffer from personality disorder and/or substance misuse. It has to do with taking ownership of your problem, as in he was more than capable to engage with the services which were on offer. And if he decided not to do so, that was his decision. This is different from someone who suffers from a psychotic illness, who is lacking capacity to do so and therefore input from an Assertive Outreach team would be more appropriate. But not for people like him, who know exactly what is right and wrong and when to when* [sic] *and he was more than capable of asking for help when he needed it.*

TC: *Was he aware that, that was the kind of agreement that you two had, that he came, approached you rather than you send out numerous letters or that actually three DNA's and you're discharged. Was that in a care plan anywhere?*

C Psychiatrist 1: *That was, that was commonplace, I mean, do we tell patients beforehand when you don't attend twice you will be discharged back to your GP? I don't think that's a protocol, but it is an idea that we should include it in the leaflet that we give to patients when you don't attend outpatient appointments without cancellation or without informing us*

the reason why, then we can't keep you on the books. But I don't think it is standard practice.'

16.14 The Independent Investigation Team believes that an individual such as Mr A must be care co-ordinated proactively in order to manage risk effectively. A failure to attend sessions should have raised issues of risk management for his care co-ordinator. It was the duty of the care co-ordinator to communicate with others involved with Mr A's care to find out what was known about Mr A's circumstances at the time and to seek to ensure that contact could be resumed. In this regard, it is relevant that Mr A was attending sessions with Consultant Psychologist 1 at this time and it may have been possible to re-establish contact through Consultant Psychologist 1. An action plan to establish re-engagement could have been included in Mr A's care plan and considered as a way of managing the risk which Mr A presented. Referral to the multidisciplinary team which included Consultant Psychologist 1, as requested by HPFT's Discharge Policy, might also have been useful in this regard.

16.15 During the course of the Investigation HPFT were invited to provide details of the current procedures in place which support the stated aim of the Operational Policy in 2005 that a multidisciplinary review takes place prior to the discharge of a patient as a result of a failure to attend.

16.16 HPFT were also invited to provide details of its current procedures regarding communication of a decision to discharge a patient exhibiting Mr A's features following non-attendance.

16.17 HPFT were further invited to provide details of its current procedures which ensure that risk assessments are completed upon discharge of a patient as a result of non-attendance and shared with all relevant parties.

16.18 HPFT's response was as follows:

'Current procedures are described in the Trust's "Did Not Attend" policy. In the past two years this has been revised with the involvement of local commissioners, and practice has been subject to audit and re-audit.'

'When a service user does not attend for an appointment, the clinician is expected always to consider the possible reasons, which may vary between the entirely innocent to the very worrying. If they conclude that the DNA does not indicate any increased risk, they must record this and their reasoning. If they conclude there is increased risk, they are expected to discuss the next response with the multi-disciplinary team and in the case of junior doctors with their Consultant.'

'If the decision is to discharge the service user from the Trust, the Transfer and Discharge policy applies. Clearly the fact of discharge, reasons for it and route back into the Trust if required, should be communicated promptly in writing to the service user their GP and other agencies involved.'

'Such decisions will not be made without consideration of the risk factors and recording of the conclusion.'

16.19 Key Points

1. Consultant Psychiatrist 1 discharged Mr A on 27 March 2007 as a result of Mr A's failure to attend 3 consecutive outpatient appointments. This discharge was not completed in accordance with HPFT's Operational Policy, which required that a service user's failure to attend two appointments should be reviewed in an MDT context.
2. In discharging Mr A, Mr A's care co-ordinator did not contact any of the organisations involved in the MAPPA process relating to Mr A or Consultant Psychologist 1, who was undertaking a course of therapy with Mr A.
3. A risk assessment of Mr A was not carried out prior to Mr A's discharge. Information relating to Mr A's risk level and current dynamic risk factors were not passed to Mr A's GP as part of the discharge process. This is a matter of concern.

16.20 Recommendation

1. HPFT should conduct an audit to ensure that patients who are discharged from care are the subject of a multidisciplinary review as a result of a failure to attend appointments.

17.0 POST DISCHARGE ON 27 MARCH 2007

17.1 Following 27 March 2007, Consultant Psychiatrist 1 maintained an involvement in Mr A's care. In a letter dated 26 April 2007 from the Public Health Directorate within HPFT to Mr A's solicitors it appears that Consultant Psychiatrist 1 felt unable to make a referral on behalf of Mr A. The letter states:

> '*Regrettably the PCT is unable to authorise funding for referral of Mr A to the Cassel Hospital for treatment.*
>
> *However we are happy for referral to the Henderson Hospital, with whom we have a Service Level Agreement, who offer a suitable care package very similar to the Cassel.*
>
> *We have spoken to Consultant Psychiatrist 1, Mr A's Psychiatrist on 18th April. He advised us that following Mr A repeated failure to attend for outpatient appointments, he has had to discharge him back to the care of his GP. Therefore Consultant Psychiatrist 1 will not be able to refer Mr A to any hospital, as things currently stand.'*

17.2 However, Mr A's solicitors subsequently sent a letter dated 21 May 2007 to Consultant Psychiatrist 1. This letter stated:

> *'We enclose a copy of a letter received from The Director of Public Health in respect of the proposed treatment of our client at the Cassel Hospital.*
> *…*
> *We believe that a formal referral will need to be made to the Henderson and wonder whether you would be in a position to make such a referral notwithstanding that you have discharged him back to the care of his GP. We are informed by the Henderson that their system for referral and assessment is dependent on pre-approved funding (which we appear to now have) and a referral from a psychiatrist. They do not accept referrals from GPs.*
>
> *Should you not be able to make the referral, could you suggest another way in which an urgent referral could be made in these circumstances.'*

17.3 Following receipt of this letter, Consultant Psychiatrist 1 wrote to the Henderson Hospital, on 22 May 2007. The letter was copied to Mr A's solicitors and GP. In his letter, he stated:

> *'Mr A has been under my care for the past five years and the therapeutic relationship has been rocky from the start, to say the least. Over the past two years Mr A has made some remarkable steps in the right direction by engaging with anger management training and the Drug and Alcohol Services…Consultant Psychiatrist 4, Consultant Psychiatrist and independent expert Witness for the Court, and I were both of the opinion that Mr A would*

benefit from treatment at the Henderson Hospital to address the deep seated personality difficulties.
Mr A is not on any prescribed medication. He has also started a limited number of CBT sessions by Consultant Psychologist 1, Psychologist, based at Edinburgh House in St Albans.
…
Please do not hesitate to contact me should you require any further additional information.'

17.4 On 30 May 2007 Consultant Psychiatrist 1 received a letter concerning Mr A from the Henderson Hospital. The letter stated:

'Thank you for referring Mr A for assessment by ourselves. In order to proceed could we please ask you for further information.

Please find enclosed a referral information form and CMHT form. Could we please also have copies of CPA and risk assessment information if this is available. Once we have received this information, we can forward the referral on for funding application.'

17.5 Consultant Psychiatrist 1 had effectively resumed his role as care co-ordinator for Mr A at this stage. The CPA Policy at Section 12.2 states that, on taking up the role of care co-ordinator, a comprehensive assessment of the user's health and social care needs should be undertaken, an assessment of risk to children and other vulnerable individuals should be carried out, and an up to date risk assessment, management and contingency plan should be put in place. A CPA Care Plan should also be completed. There is no evidence to indicate that Consultant Psychiatrist 1 took any action to ensure compliance with these requirements. Consultant Psychiatrist 1 also had no discussion with other MDT members before resuming the role of care co-ordinator. All the discussions above regarding the Henderson Hospital are further significant changes for Mr A. For example, a potential inpatient stay, which would result in potential lack of contact with loved ones and his child. This constitutes a known dynamic risk factor. Additional dynamic risk factors at this point include the effective ending of the long term therapeutic alliance with Consultant Psychiatrist 1, the recent separation from his partner and therefore his child, Mr A's ongoing dispute with CSF and the imminent end of treatment by Consultant Psychologist 1.

17.6 During the course of the Investigation HPFT were asked to provide the Independent Investigation Team with details of the policies and procedures which are in place to ensure that service users who have been discharged from care are reviewed in accordance with CPA procedures at the point of recommencement of care.

17.7 HPFT responded as follows:

'If someone who has been discharged from Trust care is re-referred, the Trust now provides a Single Point of Access service which will undertake the initial screening. Once they decide the local team needs to be involved again, an appointment either urgent or routine is arranged. At this appointment a full reassessment of needs and a risk assessment is carried out leading to a new care plan shared with the service user.'

'These procedures are described in full in the Care Co-ordination policy and the Single Point of Access operational policy.'

'The SPA does not replace strong local relationships between clinicians and referrers such as GPs. Informal advice is still provided.'

17.8 Key Points

1. On 26 April 2007, Mr A's solicitors contacted Consultant Psychiatrist 1 to facilitate a referral to the Henderson Hospital of behalf of Mr A, notwithstanding that Consultant Psychiatrist 1 had discharged Mr A.
2. Consultant Psychiatrist 1 referred Mr A to the Henderson Hospital on 22 May 2007. The Henderson Hospital responded asking Consultant Psychiatrist 1 for CPA information and to complete referral forms.
3. At this point Consultant Psychiatrist 1 effectively resumed his previous role as care co-ordinator for Mr A.
4. Mr A's care co-ordinator did not take action to ensure that the requirements of the Care Programme Approach were reviewed. In particular, he failed to carry out a risk assessment and ensure that a care programme was put in place. These are key requirements of a care co-ordinator.

17.9 Recommendation

1. HPFT should provide guidance to support staff in relation to the provision of informal advice to ensure that the rationale behind its control mechanisms and policies are not circumvented in the event that informal advice is given.

18.0 TRANSFER OF CARE CO-ORDINATOR

18.1 Transfer of care co-ordinator on 6 June 2007

18.2 On 6 June 2007, Consultant Psychiatrist 1 wrote to Consultant Psychiatrist 2, a Psychiatrist working as part of the St Albans CMHT, regarding Mr A. The letter was copied to Mr A's GP. This letter stated:

> *'Thank you for taking over the care of Mr A who is well known to the St Albans CMHT Manager and Consultant Psychologist 1 diagnosed with a dissocial personality disorder.*
> *…*
> *Mr A has been living with his mother in Harpenden for the past 6 months, formally being of no fixed abode. He is registered with Davenport House Surgery in Harpenden and I told Mr A that I would transfer his care to you now he has moved out of my catchment area. It is my understanding that as part of the court proceedings with regards to him having access to his daughter he has requested a referral to The Henderson Hospital for treatment of his personality disorder. Since Mr A was in between psychiatrists, he asked me to make the formal referral which I have done. Enclosed I will send you two forms from The Henderson Hospital, one of which I have already filled in but ideally should be signed by you. The other one is an agreement form between the psychiatrist and The Henderson Hospital for further follow up after discharge.*
>
> *Sorry that this is all a bit messy but in a sense it reflects the nature and degree of Mr A's involvement with the mental health services. I have loads of more information in his medical file and I am more than happy to copy relevant documentation for your perusal. Please do not hesitate to contact me in case you have any further questions.'*

18.3 The referral forms to the Henderson Hospital have not been provided to the Independent Investigation Team. It is not clear therefore how Consultant Psychiatrist 1 complied with the Henderson Hospital's request for CPA and risk assessment information requested on 30 May 2007 as Consultant Psychiatrist 1 had not had an opportunity to review Mr A at this time and he had last seen Mr A on 6 October 2006.

18.4 In interview Consultant Psychiatrist 1 was asked about the rationale behind Mr A's transfer:

> *C Psychiatrist 1:* *'I thought it was at that juncture a good idea for him to be onto the St Albans team because I thought, if there is a need for further intervention along the lines of Consultant Psychologist 1, maybe in terms of a CPN or social worker doing a piece of work, it couldn't come from my team, and it should come from the St Albans team.'*

18.5 Consultant Psychiatrist 1 had not spoken to Consultant Psychiatrist 2 at the time he wrote the letter dated 6 June 2007. Nor is it clear if he had spoken to Mr A about his views upon changing care co-ordinator. Consultant Psychiatrist 1's decision to refer Mr A to the Henderson Hospital despite having previously discharged him demonstrates a willingness to provide support to a complex patient in accessing psychiatric services which is an element of good practice. However, a decision to transfer Mr A whilst the possibility of a placement at the Henderson Hospital was outstanding is a matter of concern. In particular, consideration does not appear to have been given to whether Consultant Psychiatrist 2 was best placed to deal with any queries which the Henderson Hospital might have had.

18.6 There is nothing in Mr A's records to suggest that Consultant Psychiatrist 1 notified the MAPPP and the other agencies involved in Mr A's management that he was no longer acting as care co-ordinator. This is a significant concern.

18.7 Consultant Psychiatrist 1 contacted Mr A's solicitors on 7 June 2007 to inform them that Consultant Psychiatrist 2 was now formally responsible for Mr A's care as he had now moved within the St Albans catchment area for mental health services.

18.8 The St Albans CMHT Manager emailed Consultant Psychiatrist 1 on 8 June 2007 in relation to the proposed care transfer. The email read:

> *'I was very surprised to learn today that Consultant Psychiatrist 2 has been put as care co-ordinator and consultant without an appropriate CPA handover. I have therefore removed Consultant Psychiatrist 2's name until a handover is agreed as per policy.*
>
> *I remember discussing with you briefly in passing some time ago that you were making a referral to the Henderson. Given the violent history and high profile (MAPPP level 3) nature of Mr A's case it would be more appropriate and good practice that you Consultant Psychiatrist 1 (who knows him best) signs the referral with the Dacorum CMHT signing the agreement to receive care back once he is discharged. If Mr A on discharge from the Henderson chooses to live in Harpenden with his mother then a CPA handover and transfer of care can be appropriately made with the St Albans CMHT.*
>
> *Mr A is chasing Consultant Psychiatrist 2 to sign his referral documents to the Henderson. I understand he was ringing from court wanting to know if these papers were signed. We will write today advising him that we have returned these documents to you as you are best placed to complete them.'*

18.9 According to the CPA and Care Management Policy (the 'CPA Policy') in force at the time of Mr A's care, the care co-ordinator at the time of an individual moving out of

the geographical area for which they are responsible was required to carry out a CPA handover. The CPA Policy states:

> *'If a service user is due to move out of the geographical area for which the Care Coordinator and the multidisciplinary team has responsibility, the Care Co-ordinator will be responsible for initiating and setting up a review and handover meeting. This will need to specifically address the transfer of medical responsibility to the identified mental health team accepting the case. In such a situation responsibility for an individual service users care plan remains with the host service until such time as the receiving team have formally accepted responsibility.'*

18.10 The CPA Policy does not include specific guidelines for transfer between care co-ordinators or teams in the same geographical area. However, the Independent Investigation Team believe the same principles apply in order that the team accepting the transfer of an individual such as Mr A with a complex presentation have all the relevant information to ensure a smooth transition of service delivery.

18.11 Consultant Psychiatrist 2 was asked about the transfer process at the time of Mr A's care in interview. She said:

> *'C Psychiatrist 2:* *I mean what would normally happen is if somebody moves from one part of the service to another, provided they are settled, and that would normally mean that they had established themselves with a GP, they have got stable accommodation, they're* [sic] *, we would then arrange to transfer they're clinical care over to the local team, that's definitely the best normal case scenario. But that, our policy for transferring cases if there is a transfer, a care co-ordination, a CPA transfer meeting will be held.*
>
> *JH:* *Right.*
>
> *C Psychiatrist 2:* *At which that's, caring transferred from care co-ordinator to care co-ordinator with a discussions of the risks and there is normally a risk assessment carried out at that time.*
>
> *JH:* *Right.*
>
> *C Psychiatrist 2:* *So it's normally done in, well it's always done in a planned way'.*

18.12 Consultant Psychiatrist 2 wrote to Consultant Psychiatrist 1 on 29 June 2007. She noted that as a result of the SUI there was no purpose to a CPA handover meeting

and that care for Mr A in the future would be appropriately managed by the Forensic Service. She also stated:

> *'I think this particular case has highlighted some of the problems associated with transferring patients with a history of complex and challenging behaviours between teams, and I think we need to agree a protocol which, in addition to involving a CPA handover meeting, should involve a period of joint working if a transfer is agreed to be appropriate in individual cases.'*

18.13 The Independent Investigation Team is concerned by the manner in which the transfer of Mr A's care was carried out. A CPA handover meeting involving Consultant Psychologist 1, Consultant Psychiatrist 2 and professionals from other agencies engaged in MAPPA would have been beneficial for Mr A and those involved in his care. Such a handover could have included updated risk management information. In order to give certainty and continuity during what could have been a difficult transitional phase, as a result of Mr A's involvement with social services for example, there would have been considerable merit in Consultant Psychiatrist 1 continuing to act as care co-ordinator until care was transferred and Consultant Psychiatrist 2 had had an opportunity to establish a professional relationship with Mr A, potentially requiring a period of joint working of this complex individual.

18.14 The need to ensure a smooth transfer of care between practitioners is essential in the field of mental health care. Individual users may have developed a significant relationship with members of CMHTs responsible for their care that a new mental health practitioner would struggle to replicate. This may lead to a lack of engagement with mental health services or a loss of trust in the individuals responsible for mental health care. In addition, patients with borderline personality traits can also experience being discharged or transferred as a feeling of loss and rejection, which can be difficult for them to cope with.

18.15 The Independent Investigation Team has reviewed the CPA and Risk Assessment Policies in force at the time of the death of the Deceased. The Independent Investigation Team has no criticism of the content of these policies. Had they been applied they would have effected a proper transfer of care.

18.16 During the course of the Investigation were invited to provide the Independent Investigation Team with details of how it monitors the discharge process in order to ensure that the requirements of its own polices are fulfilled.

18.17 HPFT responded as follows:

'Again, a range of audits are used each year to evaluate practice in this important area. For example a recent audit has checked the timeliness of discharge notifications and summaries to GPs.'

'We now monitor our data on the proportion of service users who are re-referred following discharge within a given time period. This is partly aimed at monitoring the accuracy of SPA decisions about the most appropriate clinical response to new referrals. We exercise some caution in drawing conclusions from these data because in many ways smooth movement of service users in and out of secondary care is seen now as desirable, rather than always negative.'

18.18 Key Points

1. Consultant Psychiatrist 1 informed Consultant Psychiatrist 2 on 6 June 2007 that he was transferring responsibility for Mr A to her. Consultant Psychiatrist 1 also notified Mr A directly that Consultant Psychiatrist 2 would be acting as care co-ordinator and that Consultant Psychiatrist 2 was taking on responsibility for Mr A's transfer to the Henderson Hospital.
2. On 8 June 2007, the St Albans CMHT Manager informed Consultant Psychiatrist 1 that a formal care transfer should be carried out and that Consultant Psychiatrist 1 should continue as care co-ordinator until that took place.
3. Consultant Psychiatrist 1 attempted to transfer Mr A's care to Consultant Psychiatrist 2 without carrying out a CPA review, risk assessment or detailed letter of referral. These are central to the management of an individual's care and are required to carry out an adequate assessment of the risk of harm to service users and others.
4. Consultant Psychiatrist 1 also failed to ensure the passage of key information relating to Mr A's circumstances, including the involvement of the MAPPP, to Consultant Psychiatrist 2. Whilst it is clear that St Albans CMHT had some information about Mr A, it is still necessary for a full set of information to be handed over as part of a care transfer. This was a significant failing that could potentially have left individuals responsible for Mr A's care unaware of significant risk factors.
5. Consultant Psychiatrist 1 failed to inform other services responsible for management of Mr A of the change in care co-ordinator, including the MAPPP. This is a significant concern.
6. The Independent Investigation Team has reviewed the CPA and Risk Assessment Policies in force at the time of the death of the Deceased. The Independent Investigation Team has no criticism of the content of these policies. Had they been applied they would have effected a proper transfer of care.

19.0 CLINICAL GOVERNANCE

19.1 Multidisciplinary Team

19.2 Individuals experiencing psychosis or other mental health issues present in a number of different ways and are shaped by a complex pattern of social, physical and psychological factors.

19.3 This can cause difficulty in the clinical decision-making process. Experienced clinicians rely on a wide array of patient behaviours, characteristics and values in deciding management. Multidisciplinary team working provides assistance in meeting the increasingly complex needs of service users who require the decision-making skills of different professionals in order to enhance the provision of care.

19.4 Consultant Psychiatrist 1 was asked about the organisation of multidisciplinary team meetings of the Dacorum CMHT. He said:

> *'C Psychiatrist 1: Yes there is a multi-disciplinary team meeting every Monday afternoon, so that would also be this afternoon which I have obviously postponed, where all the team members are invited to attend. Obviously they're not coming all of them because of other commitments, but all the referrals from GP surgeries or GPs in my catchment area are discussed and signposted, either to be seen in the Outpatient Clinic by one of the medical doctors, or whether we need to do a duty assessment or whether the patient needs to be referred to other services outside St Pauls, and then we will inform the GP about that decision.*
>
> *JH: Are those meetings minuted*[sic]*?*
>
> *C Psychiatrist 1: Yes they are.*
>
> *TC: And only one MDT, not two MDTs?*
>
> *C Psychiatrist 1: Well there is one for me and one for the other Consultant Psychiatrist*
>
> *TC: And do they both happen on the same afternoon or...*
>
> *C Psychiatrist 1: No mine is on a Monday afternoon. The other Consultant Psychiatrist does it on a different day.'*

19.5 The Independent Investigation is also concerned by the structure of the MDT meeting operated by Dacorum CMHT. The meetings are structured in such a manner that the

two psychiatrists practising within the CMHT do not have an opportunity to contribute to the multidisciplinary discussion of the other's cases which could be beneficial in some of the more complex cases. Whilst administratively it may be difficult for both Psychiatrists to attend all MDT meetings, there does not appear to be any other vehicle which would allow an element of peer review or supervision of the more complex cases. This also has implications in terms of peer review and supervision.

19.6 The Independent Investigation Team could not find any evidence that Mr A's care had received any form of multidisciplinary consideration within Dacorum CMHT. During the course of his care, Mr A had a single care co-ordinator and no evidence was presented to the Independent Investigation Team that his case received MDT consideration and input as was required by HPFT policies such as the Operational Policy and CPA Policy. As a result, it appears that Consultant Psychiatrist 1 was effectively working in isolation. This is a matter of concern for the Independent Investigation Team.

19.7 The Independent Investigation Team was advised that there was no mechanism for ensuring the review of patients on a regular basis by the MDT. It appears that patients will only be brought to an MDT where a member of staff identified the case as requiring input. The Independent Investigation Team were also advised that if a case was not making progress then the advice given to the team members in supervision was to bring that case to an MDT meeting for discussion.

19.8 The absence of a mechanism to ensure systematic review of patients in an MDT context in accordance with HPFT's own policies and procedures risks a reduction in the quality of service delivery to service users. The Independent Investigation Team is concerned by the lack of systems and controls which could have highlighted a failure to submit Mr A's care for MDT discussion.

19.9 The Independent Investigation Team are concerned that potentially a key aspect of Mr A's care such as Consultant Psychologist 1's provision of anger management sessions could not be fully discussed by Dacorum CMHT because Consultant Psychologist 1 was not present at Dacorum CMHT. Equally, Consultant Psychologist 1 would not in this situation have the support of the MDT structure in St Albans should he have considered it necessary to refer Mr A for MDT consideration. This is a control weakness which could potentially have impacted on the management of Mr A's discharge and transfer. Consultant Psychiatrist 1 and Consultant Psychologist 1 attended different MDT's, therefore, even the work undertaken by two of the CMHT clinicians had the potential to be fragmented and not linked up. This is evident by

Consultant Psychiatrist 1's decision to discharge Mr A when Consultant Psychologist 1 was still offering treatment. The Independent Investigation Team does not regard this as best practice.

19.10 During the course of the Investigation HPFT are invited to supply information that the introduction of new policies and procedures ensures that there are cases now subjected to MDT discussion where required by HPFT CPA and Operational policies.

19.11 HPFT have responded as follows:

'Revisions of the CMHS Operational Policy have continued to make clear the importance of multi-disciplinary team meetings in CMHTs – amongst other things to discuss new referrals, complex or high risk current cases and discharges. Each team has such meetings on a weekly basis separately from business meetings.'

'The practice governance lead has monitored compliance with this standard via the county-wide CMHS managers' meeting.'

19.12 Key Points

1. The Independent Investigation Team could not find any evidence that Mr A's care had received any form of multidisciplinary consideration within Dacorum CMHT as required by HPFT policy. Consultant Psychiatrist 1 remained his care co-ordinator throughout his care and appears as a result to have been acting effectively in isolation.
2. The Independent Investigation Team was advised there was no mechanism for ensuring the review of patients on a regular basis by the MDT.
3. The absence of a mechanism to ensure systematic review of patients in an MDT context risks a reduction in the quality of service delivery to service users.

19.13 Recommendation

1. A review is conducted to ensure that the current CMHS Operational Policy and CPA policy includes sufficient failsafe procedures to ensure that all cases are reviewed in a multidisciplinary setting where required by internal procedures

19.14 Supervision

19.15 Clinical and professional supervision in the NHS was introduced as a way of using reflective practice and shared experiences as a part of continuing professional development.

19.16 Supervision is a cornerstone of clinical governance because it seeks to promote and engender the following:

- Quality improvement;
- Risk management and performance management; and
- Systems of accountability and responsibility.

19.17 Crucially, it provides a structured approach to deeper reflection on clinical practice. This can lead to improvements in practice and client care, and contribute to clinical risk management.

19.18 In 2005, HPFT published a Staff Supervision Policy Statement. This document contains the following statement:

> *'The Trust believes that effective supervision contributes to job satisfaction, personal development and the provision of a high quality service. Supervision is the opportunity and requirement for staff to receive guidance and support. It also enables staff to reflect on how they carry out their tasks and activities within their role and other aspects of their working lives. Supervision is a fundamental part of Practice Governance.'*

19.19 At the time of Mr A's engagement with the CMHT, HFPT had in place the 'Staff Supervision Policy Statement' dating from November 2005. This states:

> *'All staff working within HPT will have access to regular management supervision and, where appropriate, to professional and/or clinical supervision*. Supervision will take the form of a regular, planned meeting with an appropriate supervisor. For management supervision this will be usually be the line manager.*
>
> *The Trust will ensure that each member of staff has some agreed access to supervision provided by a member of their own profession, where their line manager is of a different profession. For some staff groups, management and professional and/or clinical supervision will be carried out at separate events. For others they will be combined into a single activity.*
>
> *This policy requires that all staff are supported and able to take part in management supervision, irrespective of whether they are also receiving professional and/or clinical supervision.*

All supervision (management, professional and/or clinical) should be carried out in a manner that is supportive, formative (learning-focused) and normative (ensuring expected quality standards are maintained) although the emphasis of each of these will depend on the specific context and nature of the supervision.
…
Professional Leads, Directors and Senior Managers are responsible for the implementation of this policy.
…
Management supervision should usually take place at a frequency of once every 4-6 weeks with a maximum interval of 8 weeks. Frequency for particular groups of staff will be agreed at service area level, unless otherwise specified. Practitioner and clinical staff should usually receive management supervision no less than monthly. However, newly qualified and newly appointed practitioners should usually receive management supervision at least fortnightly for an agreed period. Newly appointed non-clinical staff should receive management supervision at a frequency of at least every 4 weeks for the first six months. In certain specific cases, the frequency of management supervision may be increased.'

19.20 Clinical Supervision

19.21 Clinical supervision provides a forum for discussion of work issues within a clinical and/or professional supervision context. They also provide the opportunity to reflect on practice and relationships and to learn, implement and evaluate outcomes based on that reflection.

19.22 The HPFT Statement upon Supervision makes it clear who holds responsibility in the supervision process:

'Responsibility for supervision
Professional Leads, Directors and Senior Managers are responsible for the implementation of this policy.
Line managers are responsible for ensuring that appropriate supervision arrangements are made for each member of their staff.
Both supervisors and individual staff have a responsibility to ensure appropriate supervision takes place. Engaging in both management supervision and, where appropriate to job role, clinical and/or professional supervision, are a part of the individual's contract of employment with the Trust.'

19.23 When asked in interview regarding supervision arrangements, the Dacorum CMHT Manager noted that he was responsible for supervising front-line social workers but was not involved in supervision for medical staff. He said:

'D CMHT M: *But generally speaking, the supervision arrangement has, as other people, staff members would get, own discipline*

supervision. But that didn't always happen. But that was just sort of the general rule, so.

JH: *OK, and what happened about the medics?*

D CMHT M: *In terms of the medics, the medics had their own sort of system of management so, I wouldn't be providing any sort of management or clinical direct management or clinical supervision of the medics.*

JH: *OK, and psychology?*

D CMHT M: *Psychology, psychology were then Dacorum. We have a consultant clinical psychologist, there sort of management supervision has come from the locality manager, so, so, as it stood then, and as it sort of currently stands, their sort of direct sort of management accountability was to the locality manager.*

JH: *OK, so your role as well as manager, overall manager, was it to pull the supervision process together, to make sure that it's all happening, or is that somebody else's responsibility?*

D CMHT M: *I'd have a responsibility to ensure that, that supervision is, is being provided to staff. That probably applies a lot, a lot more in terms of social workers and CPN's, to be honest. I mean, I haven't checked to see whether medics are getting appropriate clinical and management supervision. That, that has not been something that I have taken on.'*

19.24 The Supervision Statement of Policy notes in relation to professional and clinical supervision:

'Professional and/or clinical supervision provide a forum for discussion of work issues within a professional and/or clinical context. It also provides the opportunity to reflect on practice and relationships and to learn, implement and evaluate outcomes based on that reflection.

This can be combined with management supervision or provided separately, although for some areas of practice, the importance of the separation of the two types of supervision (to enable practitioners to have a supportive reflective space) is acknowledged.

Professional Leads should provide guidance as to who should act as supervisor, where necessary. This policy requires that all direct care staff, are supported and able to receive professional and/or clinical supervision.

Professional and/or clinical supervision may take the form of group, individual or, in some specific cases, peer supervision.

For the purpose of this policy, professional and clinical supervision are subject to the same framework of expectations and requirements and are therefore considered together throughout the policy, unless otherwise specified.'

19.25 Consultant Psychologist 1 was asked about supervision arrangements in interview. He said:

'JH: *Who would be responsible for doing your supervision then?*

C Psychologist 1: *Well, that was a bit of a complicated issue. My professional manager, really, was the Trust Head of Psychology. From a professional management point of view, I was supposed to see him once a month. That was the...*

JH: *That was the plan?*

C Psychologist 1: *Yes.*

JH: *Did that happen?*

C Psychologist 1: *No, not in reality.*

JH: *How often did it happen?*

C Psychologist 1: *About once every three months.*

JH: *Right.*

C Psychologist 1: *But it became progressively less frequent as time went by. Consultant Psychiatrist 2…*

JH: *Why would that be?*

C Psychologist 1: *I don't know, but the management were aware of the issue. I think the Trust Head of Psychology tended to go to psychology staff who were in obvious difficulty and fire-fight problems rather than maintain...*

JH: *So, he was your professional supervision. Did you have management supervision as well? Was it split? Sometimes you get clinical supervision and sometimes management. It wasn't split?*

C Psychologist 1: *It wasn't split, no. However, on a more regular basis, in terms of clinical supervision, there was a group of*

psychologists that met, initially – fairly senior – initially at Edinburgh House, but I did used to go over to Watford to meetings. Peer supervision, really, it was.'

19.26 It is a matter of significant concern for the Independent Investigation Team that Mr A's care does not appear to have been discussed in supervision sessions attended by Consultant Psychologist 1. Further, the Independent Investigation Team is concerned that the results of the Internal Investigation into Mr A's care were not part of a process which would have allowed an opportunity for reflection, or peer review. This is a particular concern for the Independent Investigation Team given that Consultant Psychiatrist 1 did not appear to use the MDT forum in Mr A's care and was therefore effectively working in isolation from other MDT professionals.

19.27 During the course of the Investigation, HPFT were invited to provide the Independent Investigation Team with supervision records for Consultant Psychiatrist 1 and Consultant Psychologist 1 during the period of Mr A's care.

19.28 HPFT were also invited to provide information upon how clinical supervision takes place for senior clinical members of staff in CMHTs today and how such supervision is monitored.

18.29 HPFT responded as follows:

'These documents from 2007 are not currently in existence. The Trust Supervision Policy set out an expectation of monthly supervision for all clinical staff with a minimum of 8 weekly. The monitoring responsibilities are as set out in the policy.

- *Ensuring all staff receive management supervision*
- *Ensuring all staff with direct contact with service users receive clinical and where appropriate professional supervision.*
- *Line managers must check that supervision arrangements are cascaded through their line of responsibility through their direct reports*
- *Heads of professional groups are responsible for checking that clinical supervision arrangements described in the relevant appendices attached, take place.*
- *The Trust will include supervision audits as agreed in the Annual Audit Plan. The Reports will be reviewed by the Practice Audit Implementation Group (PAIG) and then reported on to the Quality and Risk Management Committee.*
- *In relation to medical staff generally, supervision implies a degree of professional responsibility. When senior doctors supervise trainee and SAS doctors and overtly discuss a service user they take on responsibility for clinical care and expect to be held to account.'*

'For Consultant Psychiatrists supervision is aligned with the Department of Health guidance and they receive management not clinical supervision. This is normal practice as in other trusts and in other specialties of medicine.'

19.30 Key Points

1. Clinical supervision provides a forum for discussion of work issues within a clinical and/or professional supervision context. They also provide the opportunity to reflect on practice and relationships and to learn, implement and evaluate outcomes based on that reflection.
2. It is a matter of significant concern for the Independent Investigation Team that Mr A's care does not appear to have been discussed in supervision sessions or as part of a peer review process.
3. The Independent Investigation Team are concerned that the results of the Internal Investigation into Mr A's care were not part of a process which would have allowed senior clinical practitioners an opportunity to reflect on aspects of their professional practice.

19.31 Recommendation

1. The Independent Investigation Team recommends that HPFT consider reviewing the vehicles which it has for peer review in relation to senior practitioners, in order to support professional growth within an overall quality improvement framework.

20.0 INTERNAL INVESTIGATION

20.1 Framework

20.2 In 2005, the National Reporting and Learning Service (the 'NRLS') issued guidance on communicating effectively with service users when things go wrong. Following changes to the NHS since the launch, the NRLS has reviewed the guidance and developed a new 'Being Open' framework on 19 November 2009.

20.3 The framework is a best practice guide for all healthcare staff, including boards and clinicians. It explains the principles behind 'Being Open' and outlines how to communicate with service users, their families and carers following harm.

20.4 Open and honest communication with service users is at the heart of healthcare. Research has shown that being open when things go wrong can help service users and staff to cope better with the after effects of a service user safety incident.

20.5 Background to the investigation of Mental Health Homicides

20.6 In June 2005, the Department of Health issued guidance on the investigation of serious service user safety incidents in mental health settings. The guidance was issued in an attempt to help ensure a consistent approach to investigations across the NHS and to raise standards.

20.7 In March 2008, the National Patient Safety Agency (the 'NPSA') produced further guidance describing ways in which the process of investigation could be improved with a view to identifying and communicating themes for national learning.

20.8 In its document entitled 'Independent investigation of serious patient safety incidents in mental health services good practice guidance' (the 'NPSA Guidance') the NPSA sets out a framework of best practice which aims to facilitate the root causes of incidents to be identified and communicated in an open and honest manner to all concerned. The framework was designed to guide staff through the process in a consistent manner across the NHS.

20.9 HPFT Policies and Procedures

20.10 HPFT issued a document entitled 'Learning From Adverse Events: Policy Document And Reporting & Managing Adverse Events Procedure And Investigation of Incidents, Complaints & Claims' (the 'Adverse Events Policy') in May 2007.

20.11 The death of the Deceased occurred prior to the introduction of the NPSA Guidance. The Independent Investigation Team note that the NPSA Guidance has since been incorporated into the Trust's 'Learning From Adverse Events Policy' dated October 2010. This is an example of good practice on the part of HPFT.

20.12 HPFT response to Mr A's arrest

20.13 The Deceased died in hospital from his injuries on 14 June 2007. On 21 June 2007, Watford Police contacted HPFT to advise that Mr A had been arrested on suspicion of murder in Hemel Hempstead and that they were requesting an Appropriate Adult in order to interview him. The Community Psychiatric Nurse on duty noted that Mr A was a client of Consultant Psychiatrist 1 at Dacorum CMHT and advised Watford Police that he would liaise with Dacorum CMHT.

20.14 The Community Psychiatric Nurse then contacted Dacorum CMHT. Following discussions, it was agreed that the Community Psychiatric Nurse would '*partake in appropriate adult for questioning*' at Watford Police Station. The Community Psychiatric Nurse then telephoned Watford Police Station, whereupon he was advised that Mr A had stated that he did not want an Appropriate Adult at that time.

20.15 On 22 June 2007, the following entry was made in Mr A's notes:

> *'enquiry made to Watford police [15:45] -- DC G informed me that Mr A remains in custody – no concerns re: mental health and he has a solicitor, message left with IS [sector manager] to contact duty worker [cmht] for update.'*

20.16 On 25 June 2007 the Dacorum CMHT Manager contacted Hemel Police Station who confirmed that Mr A had been charged with an offence and had been remanded in custody.

20.17 A fax dated 26 June 2007 from three CPNs at HMP Bedford was sent to Consultant Psychiatrist 1. The fax read:

> *'Re: Mr A*
> *Could you please forward any relevant information pertaining to the above named gentleman's mental health inc. any previous CPA documentation &/or previous discharge summaries to enable out team to provide efficient & appropriate treatment.'*

20.18 A consent form signed by Mr A and dated 26 June 2007 from the Medical Officer at HMP Bedford was also faxed to Consultant Psychiatrist 1 at Dacorum CMHT. The consent form reads:

'The above named person, who is at present under medical care here, states that you are currently treating him for his recent illness.
I should be grateful if you would let me have any information which could be relevant to his medical condition, (a computer printout of the medical history summary will suffice). Please note that this is for information only, to allow us to treat him currently on medication and for any significant illness.
We are unable to meet any fee incurred.
AN EARLY REPLY WOULD BE APPRECIATED ASAP'

20.19 The Independent Investigation Team has been unable to ascertain whether this information was passed to HMP Bedford.

20.20 HPFT Reporting of Incident

20.21 The Adverse Events Policy states that members of the Senior Management Team in each Directorate are primarily responsible for ensuring that all incidents/accidents are reported and incident investigations are undertaken (Section 1.5.3, Page 12 of the Adverse Events Policy). Following an adverse incident it is the responsibility of the respective Consultant and senior professional staff to ensure continuity of service user care (Section 1.5.6, Page 13 of the Adverse Events Policy). The Risk Management Department (principally through the Incidents and Claims Manager) is responsible for gathering information to report and facilitate the learning arising out of the event (Section 1.5.6, Page 13 of the Adverse Events Policy).

20.22 Initial Management Review

20.23 The Adverse Events Policy states that following the reporting of an adverse incident, the following procedure should apply:

'2.5.1 7 Day Report

For level 2 incidents and above, a 7 Day Report must be prepared within a maximum of 7 working days. This should be sent to the Senior Manager responsible for the area concerned, and the Incidents and Claims Manager.

The 7 day report contains a detailed synopsis of the incident using the basic principles of Root Cause Analysis, also giving a summary and brief history of the person involved and details of the actions taken at the time of the incident, along with recommendations provided by the Senior Manager.

This report is necessary in order to assist the team and the Senior Manager to:

- *Fully understand the seriousness and the level of the incident.*
- *Assist a Scrutiny Panel to decide what type of further investigation, if any is needed (See 2.5.3) for further information regarding the Scrutiny Panel).*

- *Provide an update to the Chief Executive and other Directors as necessary*
- *Provide the SHA with a 1 week follow up report (if this is a serious incident reported to the SHA when it occurred — see Paragraph 2.8.1)*
- *Appendix **Y**: 7 Day Report Template.'*

20.24 Report - Undated

20.25 A Report was completed in respect of this incident by the 'CMHS Manager Dacorum'. When asked in interview the Dacorum CMHT Manager stated that he had been responsible for the preparation of this Report. The Report was completed on a Trust pro forma document titled '72 Hour Report'. It is undated and unsigned. This included broad background relating to both Mr A and the Deceased.

20.26 The background given relating to Mr A reads:

> *'Throughout his contact with mental health services the consensus is that Mr A has not suffered from a mental illness however he had a personality disorder characterised by antisocial behaviour, poor impulse control and anger management coupled with substance misuse. Whilst for a significant period of time over the last 10 years he has been involved with outpatient follow up, his pattern of engagement was poor. He was discharged from outpatients appointments in March 2007 having missed three consecutive appointments. He was however seen by a Consultant Psychologist for a series of CBT oriented anger management sessions which concluded early June this year. Mr A approached the Dacorum Team Consultant again this year requesting a referral to the Henderson clinic and this referral has been made, in addition Consultant had commenced discussions with St Albans CMHC as their input would be necessary during Mr A's attendance and post discharge from the Henderson Clinic. Mr A in addition had extensive contact with drug misuse counselling agencies, probation and the Children Schools and Families Department as he was in dispute with them over contact and care arrangements over his daughter, aged one and a half years and another daughter, aged approx. 8 years of age. At the time of the alleged offence Mr A was living with his mother. His wife and daughter were not permitted to live with him by CSF, and also his wife had been the victim of alleged domestic violence by Mr A.'*

20.27 The '72 Hour Report' notes, in a box marked 'Action taken after the event':

> '*The Trust have evoked their Learning from Events Policy and a 7 Day Report is currently being completed*'.

20.28 The '72 Hour Report' does not appear to have identified any immediate concerns or learning to be developed and seems rather to have been written as the basis for the SUI Report.

20.29 This report does contain some examples of good practice. It identified that both the Deceased and Mr A had received care from the CMHT and identified the care which Mr A had been receiving, as well as his contact with other services whose interaction could have been relevant.

20.30 Serious Untoward Incident Report (the 'SUI Report')

20.31 A Serious Untoward Incident Report (SUI 121098) was completed in respect of this incident on 27 June 2007 by the Dacorum CMHT Manager. The report was commissioned by the Adult Mental Health Service Manager and appears to have been accepted as the 'final' report.

20.32 When asked about the process of preparing the SUI Report, the Dacorum CMHT Manager said:

> *'JH:* *One of the first questions I should have asked you about these reports, how did you actually go about doing it? Did you have an opportunity to talk to people, or did you simply do a review of the notes?*
>
> *D CMHT M:* *Basically, as a review of the notes, plus some, some discussion with, with professionals involved. But there wasn't a full sort of taking statement type, type process, given that sort of 7, the nature of the 7 day report is very much a quick report, identifying whether there any sort of major gaps or concerns, which usually is seen as, as a pointer for the need for any, any further investigation.*
>
> *JH:* *Had you had any training [on how], on how to do these reports?*
>
> *D CMHT M:* *In terms of the 7 day report, yes, and also I had, had training on root cause analysis.'*

20.33 The Dacorum CMHT Manager was also asked about the process for distributing the SUI Report once completed:

> *'JH:* *…I was interested in this conclusion, 'the above four points did not in my view contribute to the outcome of this incident but could be a factor in other incidents if they are not addressed.' That's very perceptive, when you hand this report in, where, where did it go to?*
>
> *D CMHT M:* *This report, sort of, once completed goes to the, the incidents department. I believe that, that there is a scrutiny*

panel that, that look at that and, and decide what, what further action sort of needs to be taken in relation to that. For example whether, there needs to be a more thorough sort of root cause analysis investigation which will involve sort of taking statements, whatever and more in depth analysis.[sic]

JH: *That didn't seem to happen in this case?*

D CMHT M: *No, no it didn't.*

JH: *Do you know why that, why there wasn't a further analysis done?*

D CMHT M: *No, I don't know.*

JH: *It wasn't fed back to you?*

D CMHT M: *No.*

JH: *Were you concerned about that? And given that sentence, it does look as if you felt that this was an important issue?*

D CMHT M: *Yeah, I did feel that was as an important issue, was one that, I felt sort of needed, some, some, some further sort of investigation.*

JH: *But nothing happened?*

D CMHT M: *Nothing happened, no.'*

20.34 The Independent Investigation Team has not been able to identify who was interviewed as part of the preparation of this report. However, in interview Consultant Psychiatrist 1 informed the Independent Investigation Team that he had not been interviewed and had not been passed the report for comment. Indeed, he was unaware who had undertaken the Internal Investigation.

20.35 Consultant Psychiatrist 1 confirmed that he had not seen the SUI Report prior to his interview as part of the Independent Investigation. During the course of interviews conducted by the Independent Investigation Team, it appears that Consultant Psychologist 1 was also unaware of the outcome of the SUI process employed by HPFT in relation to Mr A although this could have been due to his retirement which took place shortly after the Deceased's death.

20.36 The Independent Investigation Team is concerned by the apparent failure to involve key members of staff in Internal Investigations. Such reports have the

potential to highlight systems and practices which have not been effective in some way. In order for Internal Investigations to provide the greatest potential for learning, it is important that they include input from members of staff directly involved in patient care. In addition, it is important that staff have reliable access to the recommendations included in such a report.

20.37 The SUI Report gives a broad summary of the issues which arise out of Mr A's care:

> *'Based on my preliminary review of the case notes and discussion with the care coordinator it was evident that the potential for violence with Mr A was always recognised and steps had been taken or were underway to address this concern, however there was no indication that a violent incident was imminent and that the victim was at immediate risk.*
>
> *Mr A was a service user on standard CPA, the care notes records indicate a poor pattern of engagement with his care coordinator Consultant Psychiatrist 1, and as such it does not appear that a CPA review had been undertaken for some time. Given the history of violence and risk in this case plus the involvement of both psychology and psychiatry and other agencies such as CSF and Probation, it could be argued that Mr A should have been on enhanced CPA.*
>
> *The transfer process for a service user living outside the patch from Hemel Hempstead to St Albans could have been organised more efficiently.*
>
> *Whilst there had been numerous assessments of Mr A there did not appear to be a Trust risk assessment completed on Mr A which would have collated all the concerns about him, having said that Mr A has always been recognised as a potentially violent individual and this had been reflected in care note alerts, discussions at Mappa meetings etc.*
>
> *The diagnosis entered in 2005 of F20, schizophrenia was not felt to be accurate and needs to be amended.*
>
> *The above four points did not in my view contribute to the outcome of this incident but could be a factor in other incidents if they are not addressed.'*

20.38 The Independent Investigation Team broadly concur with this assessment for the reasons set out in this report, particularly those issues discussed at Chapters 14-16.

20.39 The SUI Report pro forma includes a space for Recommendations/Actions to be taken and who has responsibility for ensuring this occurs. The SUI Report on Mr A includes the following:

Recommendation	***Who is Responsible for Action***
1. *Even in situations of poor engagement a CPA review should be completed and sent to relevant parties*	*Care coordinators*
2. *High risk service users with multi-disciplinary/agency involvement should be on enhanced CPA.*	*Multi-disciplinary team*
3. *Risk assessments using the Trust format need to be completed.*	*Care coordinators*
4. *Discharge of service users who are deemed high risk should only occur after a multi disciplinary discussion*	*Care coordinators*
5. *Inaccuracies in recording diagnosis need to be dealt with.*	*Multi-disciplinary Team/Consultants*
6. *The process of transferring service users to other localities needs to be correctly adhered to.*	*Care coordinators*
7. *The development of a PD team to offer support and guidance would be of value in terms of dealing with service users such as Mr A.*	*Trust/JCT*

20.40 In addition to this, an addendum to the report has been provided to the Independent Investigation Team. This is unsigned and undated. The document was not compiled by the Dacorum CMHT Manager. Indeed, it is not clear who it was compiled by which is a matter of concern. The addendum appears to constitute an action plan.

20.41 The addendum includes the following action points:-

'3. The Incident was instructive and there are numerous learning points from which an action plan could be constructed.

Action Plan

- *CMHS manager to remind care coordinators that they should ensure that a service users diagnosis is correct and that this is reviewed at regular intervals.*
- *CMHS manager to ask consultants to ensure risk assessments are completed for all service users on standard CPA and where it is felt that the service user is high risk and not engaging with services, discharge should only occur following a CPA review and a discussion within the multi-disciplinary team.*

- *CMHS manager to remind care co-ordinators, including consultants, the procedure for transferring cases to another team and that holding on to cases outside our area should only occur in exceptional circumstances and following multi-disciplinary discussion*
- *CMHS manager to check that all service users who are on enhanced CPA have a current risk assessment.*

The above action plan is dependent on all staff using carenotes[sic]*, inputting, updating and closing cases as appropriate.'*

20.42 An Action Plan for Adverse Events was also prepared. The Action Plan is unsigned and undated. This identified a series of Root Causes/Contributory Factors and action to be taken based on the Action Plan mentioned in the above addendum. In addition it includes specific deadlines for action to be taken and a column for 'Evidence of Completion', including evidence that it had been brought to the attention of consultants. This is an example of good practice.

20.43 However, it is unclear how this Action Plan was distributed. Consultant Psychiatrist 1, when asked in interview, was unaware of the existence of the Action Plan. This is a cause for significant concern given that a number of points in the 'Actions to Address' column relate to care co-ordinators. Consultant Psychiatrist 1 specifically mentioned that he did not recall the action '*Remind consultants that they must assure risk assessments are completed for all service users on standard CPA*' being drawn to his attention.

20.44 In a letter to Consultant Psychiatrist 1 dated 29 June 2007 following the death of the Deceased, Consultant Psychiatrist 2 noted that the attempt to transfer Mr A's care had highlighted issues involved in transferring patients with a history of complex and challenging behaviours between teams. Consultant Psychiatrist 2 suggested that a protocol should be agreed requiring a period of joint working between teams in addition to a CPA handover meeting. The Independent Investigation Team supports this suggestion and recommends that it be implemented by HPFT. Consultant Psychiatrist 2 does not appear to have been interviewed in the process of preparing the SUI Report and this suggestion was not incorporated as a recommendation in the SUI Report.

20.45 In order to benefit from the issues which the SUI Report raised and the action plan which was identified, it is essential that reports are circulated to those delivering care to service users. In this case, there was a failure to do this, despite changes in practice being recommended.

20.46 During the course of the Investigation HPFT were invited to provide information upon how key documents such as reports into SUIs are distributed to all staff members who may have an interest in accessing learning following an SUI.

20.47 HPFT provided the following information:

'The Trust has a comprehensive system for sharing the learning from serious incidents – the details of which can be found in the Learning from Incidents policy.'

'Reports into SIs internally are made up of the immediate seven day reports followed by either a full RCA investigation or a Panel Review for the most serious cases. There are strict timescales for the completion of these reports that apply both internally and for the benefit of our local commissioners.'

'Once such reports are signed off, key findings are considered at Clinical Risk and Learning Lessons Group which is chaired by the Head of Patient Safety. Key points of learning are then communicated as appropriate via:

- *Distribution of the key points in the form of a learning note to practice governance forums*
- *Presentation of the key findings at professional meetings such as the Medical Staffing Committee*
- *Discussion of the learning notes at practice governance meetings leading to documented evidence of the actions other teams are going to take in response to an incident in which they were not directly involved*
- *Use of other communication routes such as articles in Sharing Good practice newsletters and workshops at the Trust's SGP conferences.'*

'All of the above applies equally to learning from independent inquiries. With these there is likely to be a greater emphasis on sharing the findings with the Executive Team and the Integrated Governance Committee.'

'The whole process of learning from incidents is administered by the corporate Patient Safety team. They work closely with the practice governance leads to ensure the key messages are acted on. To support this, this year we are also auditing the extent to which such messages have reached individual teams.

20.48 Key Points

1. HPFT became aware that Mr A had been arrested in relation to a homicide on 21 June 2007.
2. A 72 Hour Report was completed in respect of the SUI. This report contained some elements of good practice. It did not identify individuals to be interviewed or documentation to be examined.

3. A SUI Report was completed by the Dacorum CMHT Manager following the 72 Hour Report. This Report was written without interviewing key members of staff involved in Mr A's care.
4. In addition to the SUI Report, an Addendum and an Action Plan for Adverse Events were produced. The Action Plan includes a series of Root Causes/Contributory Factors and Actions to be taken. This is an example of good practice.
5. However, neither the SUI Report nor the Action Plan was distributed to key staff in the Dacorum CMHT, despite reference to staff in the action points having been made. Consultant Psychiatrist 1 stated that he had not seen the SUI Report until it was presented to him during the Independent Investigation. Consultant Psychologist 1 also had not been involved in the SUI process. This is a major concern for the Independent Investigation as it potentially denies staff important learning from the issues identified by the Internal Investigation Team relating to Mr A's care.
6. Following the death of the Deceased, Consultant Psychiatrist 2 noted that the attempt to transfer Mr A's care had highlighted issues involved in the transfer of complex patients. Consultant Psychiatrist 2 suggested that a protocol should be agreed requiring a period of joint working between teams in such circumstances. The Independent Investigation Team supports this recommendation. Consultant Psychiatrist 2 does not appear to have been interviewed in the process of preparing the SUI Report, nor incorporated into its findings.

20.49 Recommendation

1. HPFT should implement the Recommendation in its Internal Report that a protocol be agreed requiring a period of joint working in the handover process involving complex patients.

21.0 PREDICTABLE OR PREVENTABLE

21.1 The Terms of Reference of this Independent Investigation require the Independent Investigation Team to determine whether the Deceased's death was preventable or predictable.

21.2 Many Independent Investigations, like that conducted in this instance, have identified missed opportunities about the perpetrator's care or a failure to appreciate the extent of the perpetrator's difficulties to provide good quality care. In these cases, there may be evidence of failures in carrying out individual policy requirements or evidence that the care delivered may not have exhibited features of best practice. However, this does not mean that the homicide could have been either predicted or prevented.

21.3 The Independent Investigation Team has applied the following tests to assess whether the Deceased's death could have been predicted or prevented:

21.4 The homicide was predictable if there was evidence from Mr A's words, actions or behaviour that should have alerted professionals that there was a real risk of significant violence, even if this evidence had been un-noticed or misunderstood at the time it occurred.

21.5 The homicide could have been prevented if there were actions that healthcare professionals should have taken, which they did not take, that could in all probability have made a difference to the outcome. Simply establishing that there were actions that could have been taken would not provide evidence of preventability, as there are always things that could have been done better.

21.6 Predictable

21.7 The Independent Investigation Team's view is that it was predictable that Mr A could behave violently and had done so historically. This was well known to the CMHT. Mr A's violent behaviour has been documented as part of this Investigation.

21.8 A Risk Report was undertaken by a Chartered Forensic Psychologist in October 2005, which provided an assessment of static violence risk via the VRAG, an assessment of psychopathic traits via PCL-R and also highlighted some dynamic risk factors such as; use of substances, stressful situations, losing employment, difficulties gaining access to his child, and issues around abuse in his family home as a child. The VRAG suggested that 55% of offenders similar to Mr A would reoffend in

a violent manner within the next seven years and that Mr A may be at risk of committing either domestic or stranger violence in the future.

21.9 Mr A was also under the management of a Multi-Agency Public Protection Panel (MAPPP) for significant periods in the two years prior to the death of the Deceased. On 1 April 2005 Mr A was registered at Level 3, the highest level, following an incident of serious violence against his partner. He was de-registered from the MAPPA process in December 2006 but registered at Level 3 on 8 January 2007 following threats made against a social worker. This was reduced to Level 2, indicating a significant risk but without the need for senior management oversight, on 11 April 2007 and remained at Level 2 until the death of the Deceased.

21.10 The Independent Investigation Team are of the view that it was predictable that Mr A could act with significant violence and given the risk factors which he exhibited could act with sufficient force to injure.

21.11 The Independent Investigation Team note that there was no indication of imminent risk of violence by Mr A at the time of the Deceased's death. However, the Independent Investigation Team note that Consultant Psychiatrist 1 had last seen Mr A on 6 October 2006 and had not had an opportunity to identify any current dynamic risk factors since that time. In particular, if Consultant Psychiatrist 1 had a risk assessment done, then he would have had a list of dynamic risk factors as well as potential future risk factors/situations to be vigilant for when planning care for Mr A. Similarly, if he had been working effectively as a care co-ordinator, he would not have had to have direct contact with Mr A to be aware of several risk factors/situations that may impact on Mr A's level of risk, e.g. discharge from psychology, dispute over child, split with female partner, possible admission to inpatient (which could result in potential loss of contact with loved ones and child) and discharge/change of care co-ordinator. Had a risk assessment been carried out this would have provided a list of dynamic risk factors as well as potential situations to be alert to as posing an increased risk.

21.12 Preventable

21.13 None of the failures identified in this report should have happened.

21.14 However, there is no basis upon which the Independent Investigation Team could conclude that, even if Mr A had been fully and appropriately managed, such management would have resulted in psychiatric or psychological intervention, such

as medication, psychological therapy or risk management plans, which would have had an impact on his violent behaviour. Simply establishing that there were actions that could have been taken would not provide evidence of preventability, as there are always areas of care provision that could be carried out more effectively.

21.15 Even if Mr A had been fully assessed and psychiatric or psychological interventions implemented, it does not follow that the risk of violent behaviour would have been reduced. Not only is there uncertainty about the likely effectiveness of such interventions in his case but the outcome for any one individual can be influenced by a range of factors that are outside the control of professionals such as those in the Dacorum CMHT.

21.16 For example, in order to achieve significant therapeutic results through psychological interventions for personality disorders, the patient has to engage fully with the professionals providing care in order to achieve maximum benefit. Treatments are often lengthy, which increases the risk of non-engagement. The Independent Investigation Team recognises that, even had an up to date risk assessment and a risk management plan (highlighting Mr A's static and dynamic risk factors and potential future risk factors) been in place, there was no guarantee this would have prevented the death of the Deceased. Similarly, even if an up to date care plan had been devised and implemented, identifying actions to be taken in the event of disengagement from services, there was no guarantee this would have prevented the death of the Deceased.

21.17 The Independent Investigation Team recognise that treatment and management of personality disorders requires an element of buy-in from the service user, and that Mr A had at times demonstrated a poor pattern of engagement with services. While there were missed opportunities by those involved in Mr A's care to adequately assess the risk posed by Mr A, the death of the Deceased was not preventable by any member of HPFT staff.

21.18 As a result, notwithstanding the deficiencies in the delivery of care to Mr A, the Independent Investigation Team does not believe that the Deceased's death could have been prevented by members of Dacorum CMHT or St Albans CMHT in relation to their care of Mr A.

21.19 Key Points

1. The Independent Investigation Team is of the view that it was predictable that Mr A could behave violently.
2. The Independent Investigation Team does not believe that the Deceased's death was preventable by members of the Dacorum CMHT or St Albans CHMT.